DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185222	B. WING			08/13/2021	
	PROVIDER OR SUPPLIER HEPHERD HEALTH A	ND REHABILITATION		60	REET ADDRESS, CITY, STATE, ZIP CODE PHILLIPS BRANCH ROAD IELPS, KY 41553		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE API DEFICIENCY)		DBE COMPLÉTION	
F 000	A COVID-19 focus conducted on 08/1 determined no defi CFR 483.80 Infecti implemented the C Medicaid Services Control and Prever practices to prepar census was 108.	red infection control survey was 3/2021. The survey cient practice identified with 42 on Control and the facility has tenters for Medicare & (CMS) and Center for Disease ation (CDC) recommended e for COVID-19. The total		000	TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Office of Inspector General (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: ___ B, WING_ 100516 08/13/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **60 PHILLIPS BRANCH ROAD GOOD SHEPHERD HEALTH AND REHABILITAT PHELPS, KY 41553** (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 000 N 000 Initial Comments A COVID-19 focused infection control survey was conducted on 08/13/2021. The survey determined no deficient practice identified with 42 CFR 483.80.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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		185222	B. WING			08/13/2021	
NAME OF PROVIDER OR SUPPLIER GOOD SHEPHERD HEALTH AND REHABILITATION				6	TREET ADDRESS, CITY, STATE, ZIP CODE 0 PHILLIPS BRANCH ROAD PHELPS, KY 41553		
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E 000	survey was conducted deficient practice w	ed Emergency Preparedness sted on 08/13/2021. No vas identified with 42 CFR Preparedness related to	E	0000			
LABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

TITLE

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