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

PRINTED: 07/20/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		12				c					
		185222	B WING			07/1	5/2020				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
GOOD SH	EPHERD HEALTH AND I	REHABILITATION			PHILLIPS BRANCH ROAD		- 1				
				PI	HELPS, KY 41553	1					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROI DEFICIENCY)			(X5) COMPLETION DATE				
F 000	INITIAL COMMENTS	3 = 3	F	000			(ii				
	a COVID-19 focused	dard survey (KY31958) and infection control survey was									
		20 and concluded on nplaint was unsubstantiated tice was identified. The					E1				
		be in compliance with 42									
	implemented the Cer Medicaid Services (0	nters for Medicare & CMS) and Centers for				:					
	Disease Control and recommended practi COVID-19. The total	ces to prepare for									
	COVID-19. The total	1 delibus was 50.									
			i								
			!								
							:				
LABORATOR	CORECTORIS OF SHOWING	R/SUPPLIER REPRESENTATIVE'S SIGNATU	DE .		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 (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ C B. WING_ 07/15/2020 100516 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **60 PHILLIPS BRANCH ROAD GOOD SHEPHERD HEALTH AND REHABILITATION PHELPS, KY 41553** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) N 000 N 000 Initial Comments A complaint investigation (KY31958) and a COVID-19 focused infection control survey was initiated on 07/13/2020 and concluded on 07/15/2020. The complaint was unsubstantiated and no deficient practice was identified. The facility was found to be in compliance pursuant to 42 CFR 483.80.

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

TITLE

(X8) DATE

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	(X3) DA1	(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	A. BUILDING		
		185222	B. WING		0	C 7/15/2020
	ROVIDER OR SUPPLIER	REHABILITATION	STR 60 F PHI	ODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
E 000	survey was initiated concluded on 07/15/ to be in compliance	2020. The facility was found with 42 CFR 483.73 dness related to E0024. No	E 000	5		
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				TO THE STATE OF TH		
	V DIDECTORIS OF BROWNS	R/SUPPLIER REPRESENTATIVE'S SIGNATI	IDF.	TITLE		(x6) DATE

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