DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/31/2020 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			(X3) DATE SURVEY	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		1852 22	B. WING		C 08/25/2020	
NAME OF PR	ROVIDER OR SUPPLIER	<u> </u>		REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SH	EPHERD HEALTH AND	REHABILITATION	60 PH			
(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 CORR PREFIX (EACH CORRECTIVE ACTION SI TAG CROSS-REFERENCED TO THE AF DEFICIENCY)		HOULD BE COMPLETION	
F 000	An abbreviated star a COVID-19 focused initiated on 08/24/20 08/25/2020. The co and no deficient pra- facility was found to CFR 483.80 Infectio implemented the Ce	ndard survey (KY32261) and dinfection control survey was 220 and concluded on amplaint was unsubstantiated ctice was identified. The be in compliance with 42 on Control and has enters for Medicare & CMS) and Centers for d Prevention (CDC) tices to prepare for	F 000			
LABORATOR	Y DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNATI	URE	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.

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

PRINTED: 08/31/2020 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			C 08/25/2020	
NAME OF PROVIDER OR SUPPLIER GOOD SHEPHERD HEALTH AND REHABILITATION				60	REET ADDRESS, CITY, STATE, ZIP CODE PHILLIPS BRANCH ROAD IELPS, KY 41553		
(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 CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
A CO survey conciu to be i Emerg	was initiated of was initiated of was initiated on 08/25/2 in compliance was in compliance was in the was in the was initiated on the w	d Emergency Preparedness on 08/24/2020 and 2020. The facility was found with 42 CFR 483.73 chess related to E0024. No s identified.	E				

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ C B. WNG 100516 08/25/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **60 PHILLIPS BRANCH ROAD GOOD SHEPHERD HEALTH AND REHABILITATION** PHELPS, KY 41553 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID COMPLETE DATE (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 (KY32261) and a COVID-19 focused infection control survey was initiated on 08/24/2020 and concluded on 08/25/2020. 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

Office of Inspector General