STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185358	A. BUILDING **01 - MAIN BUILDING** B. WING _____	R **05/08/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD SPRINGS HEALTH AND REHABILITATION	**50 SHEPHERD LANE** **BEDFORD, KY 40006**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS Based on the acceptable Plan of Correction (POC) and the onsite revisit survey initiated and concluded on 05/08/2025, it was determined the facility had achieved substantial compliance with Life Safety Code on 05/05/2025.	{K 000}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185358	A. BUILDING _____ B. WING _____	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD SPRINGS HEALTH AND REHABILITATION	50 SHEPHERD LANE BEDFORD, KY 40006

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E 000	Initial Comments 42 CFR 483.73 Type of Structure: One (1) story (1977), Type V (000), unprotected combustible construction with four (4) smoke compartments and a complete automatic dry sprinkler system. An Emergency Preparedness Recertification Survey was conducted on 04/09/2025, in accordance with 42 Code of Federal Regulations (CFR), Subpart 483.73 (a)(3): (emergency preparedness) Requirements for Long Term Care Facilities. Bedford Springs Health and Rehabilitation was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 000		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:	E 004		5/5/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/28/2025

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.

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	185358	A. BUILDING _____ B. WING _____	04/09/2025

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E 004	Continued From page 1 (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain an Emergency Preparedness Program (EPP) in accordance with the Code of Federal Regulations (CFR) State Operations Manual (SOM), Appendix Z. The deficient practice had the potential to affect four (4) of four (4) smoke compartments, staff, and all residents. The facility had the capacity for 58 beds with a	E 004	1 The facilitys Emergency Preparedness Manual was reviewed by the Emergency Preparedness Committee and updated and approved by the QAPI Committee on 04/18/2025. 2 - The deficient practice had the potential to affect four (4) of (4) smoke compartments, staff and all residents. The	

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	185358	A. BUILDING _____ B. WING _____	04/09/2025

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E 004	Continued From page 2 census of 50 on the day of the survey. The findings include: Record review, of the facilities' EPP on 04/09/2025 at 1:41 PM, revealed the facility failed to review and update the Emergency Preparedness Program on an annual basis, the last update was documented on 04/14/2023. Interview, on 04/09/2025 at 1:42 PM with the Administrator, revealed the facility was unaware the EPP was not reviewed within a year from the date of the survey. The finding was verified by the Administrator at time of record review and at the exit interview on 04/09/2025.	E 004	updated plan will ensure all residents and staff are protected during natural disasters, man-made events, and public health emergencies. 3 The Senior Administrator educated the Administrator on 04/28/2025 regarding the requirement that the Emergency Preparedness Manual be reviewed and updated annually. The administrator verbalized understanding. 4 - The Emergency Preparedness Manual will be reviewed by the Governing Body annually and after any real emergency event. Any non-compliance will be reported and brought to the QAPI Committee for review and immediate compliance.	
E 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*	E 006		5/5/25

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E 006	Continued From page 3 (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented,	E 006		

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E 006	Continued From page 4 facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure the Emergency Preparedness Plan (EPP) was updated annually in accordance with the Code of Federal Regulations (CFR) State Operations Manual (SOM), Appendix Z. The deficient practice had the potential to affect four (4) of four (4) smoke compartments, staff, and all residents. The facility had the capacity for 58 beds with a census of 50 on the day of the survey. The findings include: Record review, of the facilities' EPP on 04/09/2025 at 1:43 PM, revealed the facility's Emergency Preparedness Plan did not contain a completed facility based and community-based risk assessment within the previous 12 months. Interview, on 04/09/2025 at 1:44 PM with the Administrator, revealed the facility was unaware the EPP did not contain the updated risk assessments. The finding was verified by the Administrator at time of record review and at the exit interview on 04/09/2025.	E 006	1 – The facility's Hazard Risk Assessment was reviewed by the Emergency Preparedness Committee and approved by the QAPI Committee on 04/18/2025. 2 – The deficient practice had the potential to affect four (4) of four (4) smoke compartments, staff and all residents. The updated HRA ensures that emergency procedures are tailored to the specific risks that are most likely and most dangerous for this facility's location and population. 3 – The Senior Administrator educated the Administrator regarding the requirement that the Facility Hazard Risk Assessment will be reviewed and updated annually. The Administrator verbalized understanding. 4 – The Emergency Preparedness Manual will be reviewed by the Governing Body annually and after any real emergency event. Any non-compliance will be reported and brought to the QAPI Committee for review and immediate compliance.	
E 029 SS=F	Development of Communication Plan CFR(s): 483.73(c) §403.748(c), §416.54(c), §418.113(c),	E 029		5/5/25

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E 029	Continued From page 5 §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.542(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain a communication plan in accordance with the Code of Federal Regulations (CFR) State Operations Manual (SOM), Appendix Z. The deficient practice had the potential to affect four (4) of four (4) smoke compartments, staff, and all residents. The facility had the capacity for 58 beds with a census of 50 on the day of the survey. The findings include: Record review, of the facilities' EPP on 04/09/2025 at 1:45 PM, revealed the facility failed to review and update the communication plan on an annual basis, documentation showed the last update 04/14/2023. Interview, with the Administrator on 04/09/2025 at 1:46 PM, revealed the facility was unaware the Communication Plan was not reviewed within a year from the date of the survey. The finding was verified by the Administrator at time of record review and at the exit interview on 04/09/2025.	E 029	1 – The facility's Communication Plan was reviewed and updated by the Emergency Preparedness Committee and approved by the QAPI Committee on 04/18/2025. 2 – The deficient practice had the potential to affect four (4) of four (4) smoke compartments, staff and all residents. The revised communication plan will ensure accurate and timely information sharing to protect residents and coordinate care with external entities during disasters. 3 – The Senior Administrator educated the Administrator regarding the requirement that the Facility Communication Plan will be reviewed and updated annually. The Administrator verbalized understanding. 4 – The Administrator or designee will: Review and update the communication plan annually and after any actual emergency event. Any non-compliance will be reported and brought to the QAPI Committee for review and immediate compliance.	

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	185358	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**04/09/2025**

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BEDFORD SPRINGS HEALTH AND REHABILITATION	**50 SHEPHERD LANE** **BEDFORD, KY 40006**

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K 000	INITIAL COMMENTS 42 CFR 483.90(a) K3 BUILDING: 0101 K6 PLAN APPROVAL: 1977 K7 SURVEY UNDER: 2012 Existing K8 SNF/NF Type of Structure: One (1) story, (1977), Type V (000), unprotected combustible construction with four (4) smoke compartments and a complete automatic dry sprinkler system. A Life Safety Recertification Survey was initiated on 04/09/2025 and concluded on 04/09/2025, in accordance with 42 Code of Federal Regulations (CFR), Subpart 483:90(a) Requirements for Long Term Care Facilities. During this Recertification Survey, Bedford Springs Nursing and Rehabilitation was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The requirement at 42 CFR, Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on	K 222		5/5/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/28/2025

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K 222	Continued From page 1 each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING	K 222		

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K 222	Continued From page 2 ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to make provisions for the rapid removal of occupants through delayed egress locks on exit doors in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) egress door, staff, and 2 residents. The facility had the capacity for 58 beds with a census of 50 on the day of the survey. The findings include: Observation, during the building inspection tour on 04/09/2025 at 12:55 PM, revealed the delayed egress door located at the Back Patio exit did not have an audible alarm when activated. Interview, on 04/09/2025 at 12:56 PM with the Maintenance Director, revealed the facility was not aware the delayed egress door did not have an audible alarm. The finding was verified by the Maintenance Director at the time of observation and by the Administrator at the exit conference on 04/09/2025.	K 222	1 – The audible alarm speaker for the identified egress door was ordered installed on 04/15/2025. 2 – The deficient practice had the potential to affect one (1) egress door, staff and two (2) residents. The maintenance director performed a check all egress door alarms on 04/10/2025 and all other door alarms sounded as required. 3 – The Maintenance Director was educated by the Administrator to the requirement that all egress doors must have an audible alarm sound when activated. 4 – The Maintenance Director will conduct a monthly audit of all egress doors for functionality, locking compliance and alarm/signal operation for compliance. Any non-compliance will be corrected immediately and the Maintenance Director will bring a copy of the inspections to QA Committee for three months for review and recommendation.	

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K 222	Continued From page 3 Actual NFPA Standard: NFPA 101 Life Safety Code, (2012) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side, unless otherwise permitted by one of the following: (1) Locks complying with 19.2.2.2.5 shall be permitted. (2) *Delayed-egress locks complying with 7.2.1.6.1 shall be permitted (3) *Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted. (4) Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted. (5) Approved existing door-locking installations shall be permitted. 7.2.1.6.1 Delayed-Egress Locking Systems. 7.2.1.6.1.1 Approved, listed, delayed-egress locking systems shall be permitted to be installed on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6 or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 11 through 43, provided that all of the following criteria are met: (1) The door leaves shall unlock in the direction of egress upon actuation of one of the following: (a) Approved, supervised automatic sprinkler system in accordance with Section 9.7 (b) Not more than one heat detector of an approved, supervised automatic fire detection system in accordance with Section 9.6 (c) Not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6 (2) The door leaves shall unlock in the direction of	K 222		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD SPRINGS HEALTH AND REHABILITATION	**50 SHEPHERD LANE BEDFORD, KY 40006**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 222	Continued From page 4 egress upon loss of power controlling the lock or locking mechanism. (3) *An irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. (4) *A readily visible, durable sign in letters not less than 1 in. (25 mm) high and not less than 1?8 in. (3.2 mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS (5) The egress side of doors equipped with delayed-egress locks shall be provided with emergency lighting in accordance with Section 7.9.	K 222		
K 781 SS=D	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed	K 781		5/5/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185358	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**04/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD SPRINGS HEALTH AND REHABILITATION	**50 SHEPHERD LANE BEDFORD, KY 40006**

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K 781	Continued From page 5 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure portable space heaters used in the facility were in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) portable space heating device, staff, and two (2) residents. The facility had the capacity for 58 beds with a census of 50 on the day of the survey. The findings include: Observation, during the building inspection tour on 04/09/2025 at 12:10 PM, revealed the facility failed to provide documentation that a heat producing portable heater located in the Unit Manager Office had a heating element that did not exceed 212 degrees Fahrenheit. Interview, on 04/09/2025 at 12:11 PM with the Maintenance Director, revealed the facility was aware of the requirements for portable heaters but was not aware that the portable heater had been brought into the building. The finding was verified by the Maintenance Director at the time of observation and the Administrator at the exit conference on 04/09/2025. Actual NFPA Standard: NFPA 101 Life Safety Code, (2012) 19.7.8 Portable Space-Heating Devices. Portable space heating devices shall be prohibited in all health care occupancies, unless both of the	K 781	1 – The portable heating device was removed immediately on 04/09/2025 by the Maintenance Director 2 – The deficient practice had to potential to affect one (1) portable device, staff and two (2) residents. A facility-wide audit of all departments and rooms was completed on 4/9/2025 to identify any other portable heaters that did not meet the two criteria. No additional heaters were found in violation. 3 – All facility staff will be educated by the Administrator beginning 04/28/2025 regarding the regulation governing the prohibited use of portable space heating devices. 4 – The Maintenance Director will complete an environmental round audit five (5) times weekly for four (4) weeks beginning 04/28/2025, then weekly for three (3) months, then quarterly ongoing and will document findings to ensure no unauthorized portable space heating devices are in use. Any non-compliance will be reported and corrected immediately. Audit results will be taken by the Maintenance Director to the QAPI Committee for three months for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185358	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**04/09/2025**

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BEDFORD SPRINGS HEALTH AND REHABILITATION	**50 SHEPHERD LANE** **BEDFORD, KY 40006**

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K 781	Continued From page 6 following criteria are met: (1) Such devices are used only in nonsleeping staff and employee areas. (2) The heating elements of such devices do not exceed 212°F (100°C).	K 781		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185358	A. BUILDING _____ B. WING _____	04/10/2025

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BEDFORD SPRINGS HEALTH AND REHABILITATION	50 SHEPHERD LANE BEDFORD, KY 40006

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F 000	INITIAL COMMENTS A Recertification Survey was concluded on 04/10/2025. The facility was found to be in substantial compliance with 42 CFR 483 Subpart B. Survey Dates: 04/08/2025 - 04/10/2025 Survey Census: 49 Sample Size: 41 Supplemental Residents: 8	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/24/2025

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.