



**CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL**

Steven L. Beshear
Governor

Sandy Goins, Regional Program Manager
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Audrey Tayse Haynes
Secretary

Maryellen B. Mynear
Inspector General

November 13, 2015

Ms. Cathy Willis
The Heritage
192 Bacon Creek Road
P O Box 1530
Corbin, Kentucky 40702

Dear Ms. Willis:

We appreciate the courtesy and cooperation extended to the representatives of this office at the time of our visit to your facility completed on October 29, 2015. This visit was for the purpose of surveying your nursing facility for compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs, and for compliance with state licensure requirements.

We are pleased to inform you that upon reviewing the results of the survey, it was determined that your facility was in substantial compliance with federal and state requirements with no significant deficiencies noted. Therefore, we will recommend that your nursing facility be relicensed and recertified for continued participation in the Title XVIII/XIX program(s), contingent upon approval from the appropriate agencies.

If you should have questions regarding this information, please contact our office.

Sincerely,

Sandy Goins / Krs
Sandy Goins
Regional Program Manager

SG:omr:lk

Enclosures

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185434	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/29/2015
NAME OF PROVIDER OR SUPPLIER THE HERITAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 192 BACON CREEK ROAD CORBIN, KY 40702	
(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	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1995</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type V (000)</p> <p>SMOKE COMPARTMENTS: Two</p> <p>FIRE ALARM: Complete automatic fire alarm system</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system</p> <p>GENERATOR: Type II natural gas generator</p> <p>A life safety code survey was initiated and concluded on 10/29/15, for compliance with Title 42, Code of Federal Regulations, §483.70 and found the facility to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	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.