DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				FOR	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u>). 0938-0391</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		185400	B. WING			05/	07/2020
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				5	06 ALLENSVILLE ROAD		
IL ANI	HEARTHSTONE PLACE			E			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	was initiated on 05/06 05/07/2020. The facili compliance with 42 C regulations and has in Medicare & Medicaid Centers for Disease C	FR 483.80 infection control nplemented the Centers for Services (CMS) and Control and Prevention practices to prepare for					
	DIRECTOR'S OR PROVIDER/9	SUPPLIER REPRESENTATIVE'S SIGNATU	RF		TITLE		(X6) DATE

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

(X6)

PRINTED: 05/20/2020

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.

DEPARTI	MENT OF HEALTH AN	D HUMAN SERVICES				FOR	MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u>). 0938-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		185400	B. WING _			05/	/07/2020
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	TONE PLACE			50	6 ALLENSVILLE ROAD		
HEARING	TONE PLACE			EL	LKTON, KY 42220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
E 000	Initial Comments		EC	000			
	Survey was initiated of concluded on 05/07/2	d Emergency Preparedness on 05/06/2020 and 020. The facility was found ith 42 CFR 483.73 related					
		SUPPLIER REPRESENTATIVE'S SIGNATU	RE		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.

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DEFICIENCIES ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	100395	B. WING		05/	07/2020	
DER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	HOULD BE		
COVID-19 Focused as initiated 05/06/20 /07/2020. The fac	020 and concluded on ility was found to be in	N 000				
	DER OR SUPPLIER SUMMARY ST (EACH DEFICIENC REGULATORY OR tial Comments COVID-19 Focuse as initiated 05/06/2 /07/2020. The fac	100395 IDER OR SUPPLIER STREET A NE PLACE 506 ALL ELKTON ELKTON SUMMARY STATEMENT OF DEFICIENCIES ELKTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	100395 B. WING DER OR SUPPLIER STREET ADDRESS, CITY, STATE, NE PLACE 506 ALLENSVILLE ROAD ELKTON, KY 42220 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG tial Comments N 000 COVID-19 Focused Infection Control Survey as initiated 05/06/2020 and concluded on /07/2020. The facility was found to be in N 000	Interview A. BUILDING: Interview B. WING IDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUBMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORR (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) ID PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) tial Comments N 000 N 000 COVID-19 Focused Infection Control Survey as initiated 05/06/2020 and concluded on /07/2020. The facility was found to be in N 000	Interview Interview	

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