DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		185399	B. WING			10/	/27/2020
NAME OF PI	ROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE		
ΗΕΔΡΤΙΔ	ND VILLA CENTER			8	3005 US HWY 60 WEST		
				L	EWISPORT, KY 42351		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	was initiated on 10/27 10/27/2020. The facil compliance with 42 C regulations and has in Medicare & Medicaid Centers for Disease C	FR 483.80 infection control mplemented the Centers for Services (CMS) and Control and Prevention I practices to prepare for					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATU	KE		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.

PRINTED: 10/27/2020

CENTER	S FOR MEDICARE & I	MEDICAID SERVICES					0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) F		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185399	B. WING			10/	27/2020
	ROVIDER OR SUPPLIER			80	IREET ADDRESS, CITY, STATE, ZIP CODE 1005 US HWY 60 WEST EWISPORT, KY 42351		
(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 CORF PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE AI DEFICIENCY)			(X5) COMPLETION DATE
E 000	Survey was initiated of concluded on 10/27/2	d Emergency Preparedness on 10/27/2020 and 020. The facility was found ith 42 CFR 483.73 related		000	DEFICIENCY)		
		SUPPLIER REPRESENTATIVE'S SIGNATUR			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.

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Office of Inspector General STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100679			(X2) MULTIPLE CC A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		B. WING		10/27/2020			
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
EARTLA	ND VILLA CENTER		6 HWY 60 WEST ORT, KY 42351				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLE THE APPROPRIATE DATE		
N 000	was initiated 10/27/2	ed Infection Control Survey 2020 and concluded on cility was found to be in t to 42 CFR 483.80.	N 000				