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

PRINTED: 06/25/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185399	B. WING	B. WING		06/11/2020	
NAME OF PROVIDER OR SUPPLIER  HEARTLAND VILLA CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  8005 US HWY 60 WEST  LEWISPORT, KY 42351			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORREC' CROSS-REFEREN	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	#KY31823 and a COO Control Survey was in concluded on 06/11/2 practice identified with control regulations an implemented the Cen Medicaid Services (C Disease Control and recommended practic COVID-19. Total cens #KY31823 was subst	ey investigating Complaint VID-19 Focused Infection nitiated on 06/09/2020 and 2020. There was no deficient th 42 CFR 483.80 infection and the facility has nters for Medicare & EMS) and Centers for Prevention (CDC) the stop investigation of the second of	F	000			
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	F	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.

Facility ID: 100679

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NAME OF PROVIDER OR SUPPLIER  HEARTLAND VILLA CENTER			•	8	STREET ADDRESS, CITY, STATE, ZIP CODE 1005 US HWY 60 WEST LEWISPORT, KY 42351		
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E 000	was initiated on 06/09 06/11/2020. There wa	ncy Preparedness Survey 0//2020 and concluded on as no deficient practice R 483.73 related to E-0024	E	000	,		

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

TITLE (X6) DATE

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Facility ID: 100679

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Office of Inspector General

NAME OF PROVIDER OR SUPPLIER HEARTLAND VILLA CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE 8005 US HWY 60 WEST LEWISPORT, KY 42351   (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING IMPORMATION)  N 000 Initial Comments FOCUSE of Infection Control Survey was initiated on 06/09/2020 and concluded on 06/11/2020. There was no deficient practice identified pursuant to 42 CFR 483.21 and 42 CFR 483.25.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPLI	TE SURVEY MPLETED			
HEARTLAND VILLA CENTER  8005 US HWY 60 WEST LEWISPORT, KY 42351  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  N 000  Initial Comments  A Complaint Survey (#KY31823) and a COVID-19 Focused Infection Control Survey was initiated on 06/09/2020 and concluded on 06/11/2020. There was no deficient practice identified pursuant to 42 CFR 483.80.  Complaint KY#31823 was substantiated with deficiencies cited pursuant to 42 CFR 483.21 and	100679			B. WING			06/11/2020			
Carried Name	NAME OF P									
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