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

PRINTED: 06/25/2020 FORM APPROVED

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT HERITAGE HALL REHAB & WELL (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 331 SOUTH MAIN STREET LAWRENCEBURG, KY 40342 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COM	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	(X3) DA	(X3) DATE SURVEY COMPLETED C		
STREET ADDRESS, CITY, STATE, ZIP CODE 331 SOUTH MAIN STREET LAWRENCEBURG, KY 40342 [X4] ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS An Abbreviated Survey investigating Complaint KY#00031845 and a COVID-19 Focused Infection Control Survey was initiated on 06/15/2020 and concluded on 06/17/2020. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for			185277	B. WING	B. WING		06/17/2020	
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	F 000	An Abbreviated Sic KY#00031845 and Infection Control Signature 15/2020 and confacility was found to CFR 483.80 infection plemented the Cimplemented the Cimplemented Services Disease Control at recommended pra	urvey investigating Complaint I a COVID-19 Focused Survey was initiated on Included on 06/17/2020. The I be in compliance with 42 I ion control regulations and has Centers for Medicare & (CMS) and Centers for Ind Prevention (CDC) I ctices to prepare for			8		
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ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DA	ABODATORY	/ DIDECTORIO OD DOC: "	DED/CUIDDUED DEDECTION	2014-7115-	<u> </u>		(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 CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
185277			B. WING		06	06/17/2020	
	PROVIDER OR SUPPLIER	T HERITAGE HALL REHAB & WE	=11	STREET ADDRESS, CITY, STATE, ZIP CODE 331 SOUTH MAIN STREET LAWRENCEBURG, KY 40342		81112020	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	HOULD BE COMPLÉTION		
E 000	Survey was initiate concluded on 06/1	sed Emergency Preparedness of on 06/15/2020 and 7/2020. The facility was found e with 42 CFR 483.73 related	E 000				
	DIRECTOR'S OR DROWN	DER/SUPPLIER REPRESENTATIVE'S SIGN		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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Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ 100431 B. WING 06/17/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 331 SOUTH MAIN STREET SIGNATURE HEALTHCARE AT HERITAGE HAL LAWRENCEBURG, KY 40342 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE **DEFICIENCY**) N 000 Initial Comments N 000 A Complaint Survey investigating Complaint KY#00031845 and a COVID-19 Focused Infection Control Survey was initiated on 06/15/2020 and concluded on 06/17/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 83.

STATE FORM

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

6899

FR4J11

TITLE

(X6) DATE