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

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
Į.		185434	B_WNG			11/09/2020	
NAME OF PROVIDER OR SUPPLIER  THE HERITAGE				1	TREET ADDRESS, CITY, STATE, ZIP CODE 92 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 PROVIDER'S PLAN OF CORRECTIVE PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROVIDENCY)		E	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS		F	000			
	conducted on 11/09/2 to be in compliance v Control and has impl Medicare & Medicaid Centers for Disease (CDC) recommended	d infection control survey was 2020. The facility was found with 42 CFR 483.80 Infection emented the Centers for I Services (CMS) and Control and Prevention d practices to prepare for ient practice was identified. s 70.					
1.400047000	DIRECTORIS OF FROM INC.	VOLIDDI IED DEDDESENTATIVE'S SIGNATURI	_		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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CENTER	S FUR WEDICARE &	MEDICAID SERVICES			CIMID IAC	7. 0530-0351
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185434	B, WING	<u> </u>	11/	09/2020
NAME OF PR	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE HERITAGE				192 BACON CREEK ROAD CORBIN, KY 40702		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
E 000	Initial Comments	9	E 00	0		
	survey was conducte was found to be in co 483.73 Emergency P	d Emergency Preparedness and on 11/09/2020. The facility ompliance with 42 CFR dreparedness related to practice was identified.	:			
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				:		
LABORATOR	Constants of the constant	RISLIPPI IER REPRESENTATIVE'S SIGNATUE		TITLE		(X6) DATE

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Event ID: DXNC11

Office of Inspector General

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		John Elieb	
		100771	B. WING		11/09/2020	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA			
THE HERITAGE 192 BACON CREEK ROAD CORBIN, KY 40702						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		D BE COMPLETE	
N 000	Initial Comments		N 000			
	conducted on 11/09/2	infection control survey was 2020. The facility was found ursuant to 42 CFR 483.80. was identified.				
			197.			
				-A		

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

TITLE

(X8) DATE