		ID HUMAN SERVICES				FOR	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LTIPLE CONSTRUCTION		E SURVEY PLETED
		185434	B. WING			12	/14/2020
NAME OF PR	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE HERI				1	92 BACON CREEK ROAD		
	IAGE			0	CORBIN, KY 40702		
(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) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	conducted on 12/14/2 to be in compliance w Control and has imple Medicare & Medicaid Centers for Disease ((CDC) recommended	Control and Prevention practices to prepare for ent practice was identified.					
	JINEGI UR 3 UR PRUVIDER/S	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.

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		185434	B. WING			12	/14/2020	
NAME OF PF	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	•		
THE HERI	TAGE				2 BACON CREEK ROAD			
				cc	ORBIN, KY 40702			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION FIX (EACH CORRECTIVE ACTION SHOULD BE G CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY			(X5) COMPLETION DATE	
E 000	Initial Comments		E	000				
	survey was conducte facility was found to b CFR 483.73 Emerger	Emergency Preparedness d on 12/14/2020. The be in compliance with 42 ncy Preparedness related to practice was identified.						
		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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OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
100771		B. WING		12/14/2020	
ROVIDER OR SUPPLIER					
TAGE					
(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH	TION SHOULD BE COMPLE THE APPROPRIATE DATE	
conducted on 12/14/2 to be in compliance p	2020. The facility was found oursuant to 42 CFR 483.80.	N 000			
	ROVIDER OR SUPPLIER TAGE SUMMARY S' (EACH DEFICIENC REGULATORY OR Initial Comments A COVID-19 focused conducted on 12/14/ to be in compliance	TAGE 192 BAC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 100771 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, TAGE 192 BACON CREEK ROAD CORBIN, KY 40702 ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Initial Comments N 000 A COVID-19 focused infection control survey was conducted on 12/14/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. N 000	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 100771 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE TAGE 192 BACON CREEK ROAD CORBIN, KY 40702 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID FREFIX TAG PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY Initial Comments N 000 N 000 000 A COVID-19 focused infection control survey was conducted on 12/14/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. N 000	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COM 100771 B. WING 12 ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12 TAGE 192 BACON CREEK ROAD CORBIN, KY 40702 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Initial Comments N 000 N 000 A COVID-19 focused infection control survey was conducted on 12/14/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. N 000

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