STATEMENT OF DEPICIPACIES (21) PROVIDERUS/PLICER 002 MULTIPLE CONSTRUCTION (21) DATE SURVEY AND CAP CORRECTION 188434 002 MULTIPLE CONSTRUCTION (21) DATE SURVEY TAME OF PROVIDER OR SUPPLICER 188434 51/04 002 MULTIPLE CONSTRUCTION 002 MULTIPLE CONSTRUCTION THE HERITAGE STREET ADDRESS, GUTY, STATE, 2P CODE 192 BACON CREEK ROAD 002 MULTIPLE CONSTRUCTION 002 MULTIPLE CONSTRUCTION PARTY RECOLUTION VIST DEPECTION DEPECTION RULE RECOVER STATEMENT OF DEPECTION RULE RECOVER STATEMENT OF DEPECTION RULE RECOVER STATEMENT ON DEPECTION RULE RULE RULE RULE RULE RULE RULE RULE	CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-0391		
IMME OF PROVIDER OF SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE UP CODE THE HERITAGE STREET ADDRESS, CITY, STATE, ZIP CODE 192 BACON CREEK ROAD CONTRICT RESULATION OF DEFICIENCES PROVIDERS FLAV OF CORRECTION & CONSTRUCT AND OF CORRECTION & RESULATION OF USCIDENT (PINO) INFORMATION PREFIX PREFIX RESULATION OF USCIDENT (PINO) INFORMATION PREFIX CARSING CONSTRUCT ACTION SINCE (CARSING CONSTRUCT ACTION SINCE CONTRUCT ACTION									
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THE HERTAGE CORBIN, KY 49702 (P4)ID TWC SUMMARY STATEMENT OF DEFICIENCIES IEACH DEFICIENCY MUST BE REPORTED BY FULL RESULATORY OR LSC DENTFRING INFORMATION) IPERX PREFIX TWC PROVIDER'S FUAN OF CORRECTION IEACH OF CORRECTION CROSS-REFERENCE AT ONE ANALONG IC CROSS-REFERENCE DEFICIENCY (INTIAL COMMENTS Image: Comparison Deficiency in Advance of the Comparison Deficiency in Advance of the Comparison Deficiency in Advance of the Comparison Compliance with 42 CFR 443.80 Unders for Disease Control and Prevention (CDC) recommended practices to prepare for CC/VID-19. No deficient practice was identified. The total census was 78. F 000	NAME OF PI	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
Prefix TXG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUIRTERS PREFix TXG CEACH OBRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE COMINTERNO F 000 INITIAL COMMENTS F 000 F 000 A COVID-19 focused infection control survey was initiated on 04/22/2020 and concluded on 04/23/2020. The facility was found to be in compliance with 42 CPR 48.30 (Infection Control and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to pream for COVID-19. No deficient practice was identified. The total census was 78. F 010	THE HERI	TAGE							
A COVID-19 focused infection control survey was initiated on 04/22/2020 and concluded on 04/23/2020. The facility was found to be in compliance with 42 CFR 483.80 Infection Control 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. No deficient practice was identified. The total census was 78.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE THE (X8) DATE		AGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS A COVID-19 focused infection control survey was initiated on 04/22/2020 and concluded on 04/23/2020. The facility was found to be in compliance with 42 CFR 483.80 Infection Control 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. No deficient practice was identified.			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)				
						TITI E		(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

PRINTED: 05/22/2020 FORM APPROVED OMB NO 0938-0391

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		185434	B. WING			04	/23/2020
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE HERI	TAGE				192 BACON CREEK ROAD		
	IAGE				CORBIN, KY 40702		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
	survey was initiated of concluded on 04/23/2 to be in compliance w	2020. The facility was found vith 42 CFR 483.73 ness related to E0024. No					
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUI	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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Office of Inspector General STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 100771			(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		B. WING		04/23/2020			
IAME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
HE HERI	TAGE		ON CREEK ROAD , KY 40702				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CORRECTION TON SHOULD BE THE APPROPRIATE CY)			
N 000	Initial Comments		N 000				
	initiated on 04/22/202 04/23/2020. The fac	ility was found to be in to 42 CFR 483.80. No					
30RATORY I	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUF	RE	TITLE		(X6) DA	