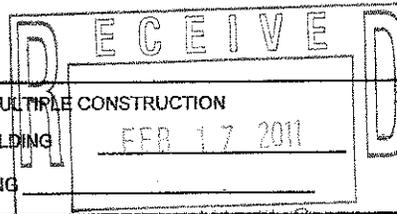


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 02/09/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185434	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2011
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NAME OF PROVIDER OR SUPPLIER THE HERITAGE	Division of Health Care STREET ADDRESS, CITY, STATE, ZIP CODE SOUTHERN LIFE CENTER 152 BACON CREEK ROAD, P O BOX 1530 CORBIN, KY 40702
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000		
F 371 SS=D	<p>483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to store, prepare, and distribute food under sanitary conditions as evidenced by the grease trap underneath the stove top in need of cleaning, the employees' hand washing lavatory only providing cold water for employee hand washing, and a garbage can in need of cleaning.</p> <p>The findings include:</p> <p>1. An initial tour was conducted in the kitchen at 6:08 p.m. on January 24, 2011. During the tour, the grease trap underneath the stove top was observed to have food debris with grease/oil also standing in the grease trap underneath aluminum foil.</p> <p>Interview with a dietary employee at 6:10 p.m. on</p>	F 371	<p>The Heritage Nursing Facility does not believe and does not admit any deficiencies existed, either before, during or after the survey. The Heritage Nursing facility reserves the right to contest the survey findings through informal dispute resolution, formal legal appeal proceedings or any administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds, nor is meant to establish any standard of care, contract obligation or position and The Heritage Nursing Facility reserves the right to raise all possible contentions and defenses in any type of civil or criminal claims, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self-critical examination privileges which The Heritage Nursing Facility does not waive, and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Heritage Nursing Facility offers the responses, credible allegations of compliance and plan of correction as part of its ongoing effort to provide quality care to its residents.</p> <p>It is and always has been the policy of The Heritage to procure food from</p>	01/29/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cathy Willis</i>	TITLE <i>Adm.</i>	(X6) DATE <i>02/15/11</i>
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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: 185434	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2011
NAME OF PROVIDER OR SUPPLIER THE HERITAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 192 BACON CREEK ROAD, P O BOX 1530 CORBIN, KY 40702	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	<p>Continued From page 1</p> <p>January 24, 2011, revealed the stove was supposed to have been cleaned on Sunday, January 23, 2011, but the employee stated the stove had not been cleaned as scheduled.</p> <p>2. Tray line observation was conducted at 11:15 a.m. on January 25, 2011. Observation of the employee hand washing lavatory (sink) revealed the lavatory was only providing cold water for the kitchen employees to wash their hands.</p> <p>Interview with two dietary employees at 11:15 a.m. on January 25, 2011, revealed the water was cold at different intervals at the hand washing sink. The employees further stated the water at the sink had been "messed up for a while."</p> <p>3. A sanitation tour was conducted in the kitchen at 1:55 p.m. on January 27, 2011. A garbage can was observed to have soured milk in the bottom of the can with a strong odor of soured milk emitting from the garbage can when the can liner was removed.</p> <p>An interview conducted with a dietary employee at 2:05 p.m. on January 27, 2011, revealed the employee had no knowledge of when the garbage can was last cleaned; but the employee stated the garbage cans were supposed to be rinsed daily.</p>	F 371	<p>sources approved or considered satisfactory be Federal, State or local authorities; and to store, prepare, distribute and serve food under sanitary conditions.</p> <ol style="list-style-type: none"> 1. An inservice was conducted on January 28, 2011 and January 29, 2011 for all Dietary staff to address the issues identified as a result of the survey. Staff were instructed to notify the Maintenance Supervisor in the event of lack of hot water at the handwashing sink, to follow proper cleaning procedure of the grease trap on the stove top, as well as following the cleaning schedule, and to rinse garbage cans daily to remove all debris and odors. 2. All residents will be provided with food that is stored, prepared, distributed and served under sanitary conditions. 3. Maintenance will conduct weekly water temperature checks on the handwashing sink. Dietary Manager will review cleaning schedule on a regular basis to ensure that all cleaning duties have been accomplished. 4. Through our Quality Assurance program, sanitation practices in the Dietary Department will be monitored quarterly. 	

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

PRINTED: 08/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185434	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/25/2011
NAME OF PROVIDER OR SUPPLIER THE HERITAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 192 BACON CREEK ROAD, P O BOX 1530 CORBIN, KY 40702		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	<p>INITIAL COMMENTS</p> <p>A life safety code survey was initiated and concluded on January 25, 2011, for compliance with Title 42, Code of Federal Regulations, §483.70 and found the facility in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			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.