DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/06/2020 FORM APPROVED OMB NO. 0938-0391

CENTER	S FUR MEDICARE &	MEDICAID SERVICES			CIND 110. 0000-0001	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185339	B. WING		C 07/24/2020	
		100000			07/31/2020	
NAME OF PR	ROVIDER OR SUPPLIER		1	ET ADDRESS, CITY, STATE, ZIP CODE		
IRVINE NI	IRSING AND REHABILIT	TATION CENTER		BERTHA WALLACE DRIVE		
	MONO AND MEMBER		IRVII	NE, KY 40336		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
F 000	An abbreviated stan	dard survey (KY31951) and Infection control survey was	F 000			
	initiated on 07/30/20: 07/31/2020. The cor and no deficient practically was found to CFR 483.80 Infection implemented the Cer	20 and concluded on implaint was unsubstantiated etice was identified. The be in compliance with 42 in Control and has inters for Medicare & CMS) and Centers for Prevention (CDC) ideas to prepare for				
LABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNATI	URE	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.

Facility ID: 100437

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

PRINTED: 08/06/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		i	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		10	185339	B. WING	B_ WING		C 07/31/2020	
NAME OF PROVIDER OR SUPPLIER IRVINE NURSING AND REHABILITATION CENTER					STREET ADDRESS, CITY, STATE, ZIP CODE 411 BERTHA WALLACE DRIVE IRVINE, KY 40336			
(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 CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE
E 000	Initial Comments			E	000			:
	A COVID-19 focused survey was initiated of concluded on 07/31/2 to be in compliance w Emergency Prepared deficient practice was	n 07/30/2 020. The tith 42 CF ness relat	020 and facility was found R 483.73 ed to E0024. No	:		F		
	8							
		59						:
	· S							
								3
	-							·,
LABORATORY	! DIRECTOR'S OR PROVIDER/	SUPPLIER RI	PRESENTATIVE'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.

Office of Inspector General (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER COMPLETED AND PLAN OF CORRECTION A, BUILDING: _ С B. WNG_ 07/31/2020 100437 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **411 BERTHA WALLACE DRIVE** IRVINE NURSING AND REHABILITATION CENTER IRVINE, KY 40336 (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 000 N 000 Initial Comments A complaint investigation (KY31951) and a COVID-19 focused infection control survey was initiated on 07/30/2020 and concluded on 07/31/2020. The complaint was unsubstantiated and no deficient practice was identified. The facility was found to be in compliance pursuant to 42 CFR 483.80.

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

TITLE

(X6) DATE