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

PRINTED: 06/18/2020 FORM APPROVED OMB NO. 0938-0391

CENTER	3 FOR MITDICAKE OF	VIEDICAID SERVICES			CIVID IVO. USC	10-0331
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185103	B. WNG		06/15/20	320
	ROVIDER OR SUPPLIER	HABILITATION CENTER	11	TREET ADDRESS, CITY, STATE, ZIP CODE 043 BROOKLYN BOULEVARD BEREA, KY 40403		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COM	(X5) IPLETION DATE
F 000	A COVID-19 focused conducted on 06/15/2 to be in compliance v Control and has impl Medicare & Medicaid Centers for Disease (CDC) recommended	f infection control survey was 2020. The facility was found with 42 CFR 483.80 Infection emented the Centers for Services (CMS) and Control and Prevention d practices to prepare for lient practice was identified.	F 000			
						NATE:
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATU	KE	TITLE	(X6) □	MIE

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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OLIVILIA	O I OIT MEDIOAITE &	MEDIONID SCITTIONS				CIVID INC	<u>i. 0830-039 i.</u>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		185103	B. WING			06/	15/2020	
NAME OF PROVIDER OR SUPPLIER THE TERRACE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1043 BROOKLYN BOULEVARD BEREA, KY 40403				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SHOULD BE		
E 000	survey was conducte facility was found to b CFR 483.73 Emerger	I Emergency Preparedness d on 06/15/2020. The se in compliance with 42 ncy Preparedness related to practice was identified.	E	0000				
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE	

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PRINTED: 06/18/2020 FORM APPROVED Office of Inspector General STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING: _ B. WNG_ 100737 06/15/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1043 BROOKLYN BOULEVARD THE TERRACE NURSING AND REHABILITATION CEN **BEREA, KY 40403** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 000 N 000 Initial Comments A COVID-19 focused infection control survey was conducted on 06/15/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. No deficient practice was identified.

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

TITLE

(X6) DATE