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

PRINTED: 05/20/2020 FORM APPROVED OMB NO. 0938-0391

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPI	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER CLINTON PLACE STREET ADDRESS, CITY, STATE, ZIP CODE 106 PADGETT DRIVE CLINTON, KY 42031 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 106 PADGETT DRIVE CLINTON, KY 42031 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL TAG CROSS-REFERENCED TO THE APPROPRIATE			185469	B. WING _			04/	22/2020
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE: OUT OF THE APPROPRIATE DESCRIPTION SHOULD BE COMPILED. TO SHOULD BE COMPILED. DATE: OUT OF THE APPROPRIATE DESCRIPTION SHOULD BE COMPILED. DATE: OUT OF TH				•	106 PADGETT DRIVE	DE		
	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
A COVID-19 Focused Infection Control Survey was initiated on 04/21/2020 and concluded on 04/22/2020. There was no deficient practice identified with 42 CFR 483.80 infection control regulations and the facility has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 63.		A COVID-19 Focuse was initiated on 04/2 ⁻ 04/22/2020. There wa identified with 42 CFF regulations and the fa Centers for Medicare and Centers for Disea (CDC) recommended COVID-19. Total cens	d Infection Control Survey 1/2020 and concluded on as no deficient practice R 483.80 infection control acility has implemented the & Medicaid Services (CMS) ase Control and Prevention d practices to prepare for sus 63.					(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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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185469	B. WING		04/22/2020	
NAME OF PROVIDER OR SUPPLIER CLINTON PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 106 PADGETT DRIVE CLINTON, KY 42031	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Survey was initiated of concluded on 04/22/2	2020. There was no ntified with 42 CFR 483.73	E 000			
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	=	TITLE		(X6) DATE

(X6) DATE TITLE

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 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(3) DATE SURVEY COMPLETED	
100181		B. WING	B. WING			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 106 PADGETT DRIVE CLINTON, KY 42031						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 000	A COVID-19 Focused was initiated 04/21/20	I Infection Control Survey 020 and concluded on as no deficient practice 42 CFR 483.80.	N 000			

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

TITLE (X6) DATE