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

PRINTED: 01/02/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185326	B. WING		10	10/21/2020	
NAME OF PROVIDER OR SUPPLIER CLINTON-HICKMAN COUNTY NURSING FACILITY				STREET ADDRESS, CITY, STATE, ZIP CODE 366 SOUTH WASHINGTON STREET CLINTON, KY 42031			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 000	was initiated on 10/10/21/2020. The facompliance with 42 regulations and has Medicare & Medica Centers for Diseas (CDC) recommend COVID-19. Total c	sed Infection Control Survey (20/2020 and concluded on acility was found to be in CFR 483.80 infection control is implemented the Centers for aid Services (CMS) and Control and Prevention ed practices to prepare for	FO	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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA [*]	(X3) DATE SURVEY COMPLETED	
		185326	B. WING		10	10/21/2020	
NAME OF PROVIDER OR SUPPLIER CLINTON-HICKMAN COUNTY NURSING FACILITY				STREET ADDRESS, CITY, STATE, ZIP CODE 366 SOUTH WASHINGTON STREET CLINTON, KY 42031			
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E 000	Survey was initiated concluded on 10/2	sed Emergency Preparedness d on 10/20/2020 and 1/2020. The facility was found with 42 CFR 483.73 related	EO				
AROBATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	IATLIDE	TITLE		(X6) DATE	

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Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ B. WING 100180 10/21/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **366 SOUTH WASHINGTON STREET CLINTON-HICKMAN COUNTY NURSING FACIL** CLINTON, KY 42031 SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE DATE (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated 10/20/2020 and concluded on 10/21/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. Total census 34.

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

TITLE

(X6) DATE