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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185326	A. BUILDING ______ B. WING ______	11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON-HICKMAN COUNTY NURSING FACILITY	**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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was initiated on 11/10/2020 and concluded on 11/16/2020 with deficiencies cited at the highest Scope and Severity of a "F". The facility was found not to be in compliance with 42 CFR 483.80 infection control regulations and had not implemented the Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census was 36.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Electronically Signed

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185326	A. BUILDING ______ B. WING ______	11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON-HICKMAN COUNTY NURSING FACILITY	**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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 1 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185326	A. BUILDING ______ B. WING ______	11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON-HICKMAN COUNTY NURSING FACILITY	**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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2	F 880		

The facility will conduct an annual review of its IPCP and update their program, as necessary.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the Centers for Medicare and Medicaid (CDC) practices and facility's policy, it was determined the facility failed to implement the use of appropriate Personnel Protective Equipment (PPE) for three (3) of eight (8) sampled residents (Resident #3, Residents #6, and Resident #8), who were newly admitted or readmitted residents to the facility.

The findings include:

Review of the 11/04/2020 Interim Infection Prevention and Control Recommendations for Healthcare Personnel during the Coronavirus Disease 2019 (COVID-19) Pandemic; from CDC home website revealed the recommended infection prevention and control (IPC) practices, for a patient that was admitted with suspected or confirmed COVID included; place the patient in a single room with door closed. Personnel entering the room should use PPE. PPE recommended when caring for a patient with suspected or confirmed COVID-19 includes the following: Respirator or Facemask (N95 respirator, Disposable respirators and facemasks), goggles or a face shield. Protective eyewear (e.g., safety glasses, trauma glasses), gloves, and gowns.

Review of the facility's policy titled, "Cohorting Residents and Isolation for COVID 19,", last revised 10/05/2020 revealed residents who were a new admission, who were asymptomatic and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185326	A. BUILDING ______ B. WING ______	11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON-HICKMAN COUNTY NURSING FACILITY	**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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 3	F 880		

COVID 19 negative, and readmissions would be admitted to the yellow zone if there were positive cases in the facility, The yellow zone was for new admissions who were asymptomatic and COVID 19 negative. However, further review revealed the policy did not address when there was no positive cases in the facility, when there was no longer a yellow zone, what isolation precautions the resident would be placed on, and what PPE needed to be worn by staff.

Interview with the Regional State Infection Control Nurse (RIFCN) for Region 10 (Western Kentucky{KY}) of the Commonwealth, on 11/16/2020 at 9:28 AM, revealed the following guidance (cohorting of residents dated 08/26/2020) from the Department of Public Health (DPH) was sent via e-mail to the facility's IFCN on 10/13/2020 related to admissions and readmissions.

Review of "YELLOW ZONE" guidance for admission and readmission of residents: provided via email by RIFCN, on 11/16/2020 at 9:28 AM, revealed if asymptomatic, COVID-19 negative residents with known or potential exposure (new admissions, Residents returning from the hospital, Residents who frequently travel outside of the facility {(i.e. hemodialysis appointments}, and roommates of COVID-19 positive residents, should be located in a unit near an entrance/exit with clearly defined unit borders (i.e. fire doors or plastic barriers) and be an area with dedicated equipment. The staffing should be dedicated nursing and environmental staff and have no resident or staff contact with the Red or Green zones. The Personal Protective Equipment (PPE) required in providing care of the above resident would be full PPE (eye protection {face shield or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185326	A. BUILDING ______ B. WING ______	11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON-HICKMAN COUNTY NURSING FACILITY	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 4	F 880		

goggles}, gown, gloves, and mask {surgical mask for aerosol-generating procedures, N95 should be used if available and staff are fit tested}. Residents should be moved to a green zone when at the end of (14) fourteen days, if asymptomatic. Green zone was defined as asymptomatic residents/COVID-19 negative residents with no known or potential exposure and care provided under normal operations consistent with current long-term care guidelines.

Observation on 11/10/20 at 11:10 AM, revealed documentation at the entrance of the facility stated "AS OF 11/02/2020, 2 POSITIVE EMPLOYEES".

Review of the admission of residents' list provided by the facility revealed, Resident #3 was admitted on 11/03/2020, Resident #8 was admitted on 11/05/2020 and Resident #6 was readmitted to the facility on 11/13/2020.

However, observation on 11/10/2020 at approximately 11:50 AM during tour of the facility, revealed Resident #3 in the doorway of the room. There was no PPE storage (gown, gloves, mask, face-shields) outside Resident #3's room or on the door. Further observation revealed there were no resident rooms, including Resident #6 or Resident #8 in the facility with signage on the door that indicated the residents were on any precautions, or of any storage of PPE at the entrance to the residents' rooms or on the doors. In addition, the facility did not have a COVID unit or an identified yellow zone.

Interviews on 11/11/2020, with Licensed Practical Nurse (LPN) #3, at 1:07 AM; 11/13/2020 with Certified Medication Aide (CMA) #1, at 7:57 AM;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185326	A. BUILDING ______ B. WING ______	11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON-HICKMAN COUNTY NURSING FACILITY	**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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 5	F 880		

CMA #2 at 8:18 AM; and, Licensed Practical Nurse #1 at 8:34 AM, revealed there were no residents on isolation precautions at "this time".

Interview with LPN #2, on 11/14/2020 at 8:57 AM, revealed there were no residents on isolation precautions at that time. She stated the last time any residents were on isolation was when they had the COVID unit. LPN #2 stated new admissions were required to be placed in isolation for 14 days and staff were to wear gloves, mask, and N95 with a mask face shield. She stated all new admits were supposed to be cared for as if they have COVID. She stated she cared for Resident #3 (who was a new admission) and he/she was not on isolation.

Interview with Registered Nurse (RN) #2, on 11/15/2020 at 10:40 AM, revealed there were no residents on isolation precautions at that time. She stated the facility was not screening (testing the residents at the facility) at this time because they did not have a COVID unit. Further interview revealed when the facility had the COVID Unit, residents were placed on isolation for fourteen (14) days when they came out of the hospital. RN #2 stated if the resident had no signs or symptoms of COVID, they would no longer be on isolation precautions.

Interview with RN #3, on 11/12/2020 at 2:30 PM, revealed that new admission were on droplet isolation for 14 days, but there were no new admissions. She stated she had worn only a facemask, N95 mask, and gloves when assessing Resident #3.

Interview with RN #1, on 11/13/2020 at 8:39 AM, revealed when they had new admissions, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185326	A. BUILDING ______ B. WING ______	11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON-HICKMAN COUNTY NURSING FACILITY	**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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6 residents were placed on droplet precautions for fourteen (14) days. She stated there were no residents on isolation and it had been two to three (2-3) weeks since anyone on isolation. RN #1 stated staff wore gowns, gloves, N95 with facemasks and shields. However, she stated there were no new admissions at "this time". She stated she had obtained Resident #3's vital signs and assessed his/her incision with gloves, facemask and N95 in place, but she had not worn a face shield, gown or booties while assessing the resident. Interview with facility's Infection Control Nurse (IFCN), on 11/12/2020 at 3:34 PM, revealed new admissions were isolated in their room, for seven (7) days and staff had to wear a N95 and paper mask, but they did not need to wear a gown. She stated they were not testing new admits or readmits unless symptomatic. She stated it was in the facility's admission and readmission policy for COVID; however, review of the policy revealed it did not contain this information. The IFCN stated that residents were not placed on isolation precautions, but they placed an isolation bag on the door so there were gowns and gloves on the door. When interviewed related to the reason the isolation bag was placed on the door since the IFCN stated residents were not on isolation precautions, the IFCN did not answer. She stated that when residents were first admitted or readmitted, they were put in a room by themselves for seven to fourteen (7-14) days. Interview with facility's IFCN and Director of Nursing (DON), on 11/16/2020 at 11:16 AM, revealed the COVID unit was broken down 11/02/2020 and the facility did not have zones anymore.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185326	A. BUILDING ______ B. WING ______	11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON-HICKMAN COUNTY NURSING FACILITY	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 7	F 880		

Review of email dated 11/11/2020 from facility IFCN to RIFCN revealed the following information: that the facility had no new cases in the facility at this time

Further interview with DON on 11/16/2020 at 11:40 AM and 3:19 PM, revealed when asked about isolation precautions for newly admitted and readmitted residents, she stated that she could not say exactly, but if the residents were asymptomatic they were isolated for ten (10) days. If they were symptomatic, they were isolated for fourteen (14) days, and if someone was severely immunosuppressed, that would be a different time. She stated staff do not have to be in full PPE when providing care to these residents, but staff use masks and gloves. The DON stated the facility did not have any residents with signs and symptoms of COVID or in isolation.

Interview with Administrator on 11/12/2020 at 11:25 AM, and on 11/16/2020 at 3:19 PM, revealed the facility no longer had a dedicated COVID unit, She stated the facility worked with the local health department, and they did not do anything without public health and Medical Director, stating that was their guidance.

Interview on 11/16/2020 at 8:39 AM, with Regional Epidemiologist (RE) revealed she assumed the facility followed CMS guidance. The RE stated she did not think that the facility really knew what they were supposed to be doing. Her understanding was the county was red and the facility was supposed to test residents weekly, if in the critical incidence rate. She stated she had not been asked by facility for guidance related to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185326	A. BUILDING ______ B. WING ______	11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON-HICKMAN COUNTY NURSING FACILITY	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 8 testing of residents/or of frequency, and she had spoken with the facility IFCN. When asked about admissions or readmissions RE stated she had not given any guidance for new admissions to them specifically, and to her knowledge they have not asked. RE stated quarantine meant if employees provided care to a resident in quarantine, staff were to wear full PPE which was mask, gown and gloves and signage should be placed on the resident's door. In addition, eye protection which was either goggles or a shield if they have available. RE stated she did not recall a time when the facility has asked her about this and if they had she usually referred facilities to the CDC for guidance.	F 880		
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19;	F 886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185326	A. BUILDING ______ B. WING ______	11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON-HICKMAN COUNTY NURSING FACILITY	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 9	F 886		

(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident ' s testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185326	A. BUILDING ______ B. WING ______	11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON-HICKMAN COUNTY NURSING FACILITY	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 10 processing test results. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review and the Kentucky Department of Public Health (KDPH) site map , it was determined the facility failed to ensure testing of residents in a timely manner related to COVID-19 pandemic positivity rates within the region. The findings include: Observation on 11/10/20 at 11:10 AM, revealed documentation at the entrance of the facility stated "AS OF 11/02/2020, 2 POSITIVE EMPLOYEES". Review of the Kentucky Department of Public Health (KDPH) site Kentucky Map, dated 11/09/2020 revealed Hickman County was shaded red which indicated all staff and residents in Long Term Care facilities needed to be tested for COVID 19 twice a week. Interview with the Administrator, on 11/16/2020 at 3:19 PM, revealed the county was shaded orange prior to that. Further review of the map revealed orange indicated all residents and staff should be tested weekly. Review of email written documentation provided by the Administrator on 11/13/2020, revealed the last COVID testing of residents was on 10/30/2020. However, prior to 11/09/2020, staff and residents were supposed to be tested weekly, after 11/09/2020, resident were supposed to be tested two (2) times weekly; per the Kentucky Map at the KDPH site. Further review	F 886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185326	A. BUILDING ______ B. WING ______	11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON-HICKMAN COUNTY NURSING FACILITY	**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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 11	F 886		

of the email documentation revealed resident testing information, dated 11/02/2020, stated residents would be screened daily for signs/symptoms of COVID, and would be rapid tested if there were signs/symptoms (s/sxs), then followed by a lab test for confirmation. After a positive rapid test, the resident would be placed on droplet precautions until confirmed, and if confirmed, the protocol would be followed, per policy.

Interview on 11/12/2020 at 3:34 PM, with the facility's Infection Control Nurse (IFCN), revealed the facility was not testing residents and was advised by the Medical Director that unless the resident was having s/sx, they were not supposed to test residents. She stated the facility was following the Centers for Disease Control (CDC) guidelines. She further stated she did not remember the last day a resident was tested.

Interview with the Regional IFCN (Infection Control Nurse) for Region 10 [Western Kentucky (KY)] of the Commonwealth, on 11/16/2020 at 9:28 AM, revealed she had been in contact with the facility's IFCN and Director of Nursing (DON) via email offering guidance. She stated she had recommended a teleconference with the Department of Public Health to provide information because the facility seemed to be struggling. The Regional IFCN stated she had informed the facility that the meeting was non-regulatory and was a way to help facilities fight COVID. Further interview revealed that she had reached out several times and informed the facility of her available schedule for a conference-call with the HAI-AR (Healthcare Associated Infection/Antimicrobial Resistance Prevention Program) team since the facility's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185326	A. BUILDING ______ B. WING ______	11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON-HICKMAN COUNTY NURSING FACILITY	**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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 12 numbers of positivity were going up. She stated the teleconference would have included information on testing frequency. She further stated the facility's IFCN responded on 11/11/2020 that they appreciated the offer, but they were working with the LHD (locate health department). Further interview with facility IFCN and DON, on 11/16/2020 at 11:16 AM, revealed the last testing of residents was in October 2020. Interview with Local Health Department (LHD) Epidemiologist, on 11/16/2020 at 8:29 AM, revealed she had been in contact with the facility and that she assumed they were looking at CMS guidance for testing as the LHD was only in a guiding advisory role. She stated it was her understanding that residents were supposed to be tested weekly if in the critical incidence rate. Further interview revealed the facility called weekly and she spoke with the IFCN related to testing, but not on the frequency of testing. She stated the facility had not asked her about frequency for testing of the residents or staff. She revealed she spoke with the facility on 11/13/2020; and was told they were not going to test the whole facility, but they did not say why. Interview with Medical Director, on 11/16/2020 at 10:16 AM, revealed the facility had routine meetings to ensure the facility was following the guidelines from the LHD and CMS. He stated it was the responsibility of the DON, IFCN, Administrator and himself to follow the guidelines. The Medical Director further stated that due to the recent increase in local numbers he did think testing needed to be more frequent at "this point". He further stated he was not aware of any conference call offered by the Department of	F 886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185326	A. BUILDING ______ B. WING ______	11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON-HICKMAN COUNTY NURSING FACILITY	**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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 13 Public Health to provide guidance and he would have been more than happy to participate. Interview with Administrator, on 11/12/2020 at 3:05 PM; and, on 11/16/2020 at 2:00 PM and 3:19 PM, revealed she did not think the facility had tested any resident in the last two (2) weeks. The Administrator stated she utilized CDC/CMS/ LHD/KYDPH/ and Medical Director as references. She stated she had just heard of the regional IFCN emails that morning (11/16/2020); and, of the offer for the meeting but it was not regulatory, and she had not known of it until that morning. Further interview with the Administrator revealed that testing of the residents made them anxious. She revealed she discussed this with the Medical Director; and he stated if residents tested negative for COVID, there was no need to test any further unless they were symptomatic. She stated that everything was done with the guidance from LHD and Medical Director. The Administrator stated the county was orange and the LHD confirmed it was orange. She revealed the dynamics had changed and all residents were "tested today" and would be tested twice weekly. She stated she had seen the rate at 10:30 PM, on Friday night (11/13/2020) on the COVID 19 site, but the county had been orange since 11/02/2020. She revealed the facility made the decision "this morning" (11/16/2020) with the Medical Director to start testing the residents.	F 886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185326	A. BUILDING ______ B. WING ______	11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON-HICKMAN COUNTY NURSING FACILITY	**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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was initiated on 11/10/2020 and concluded on 11/16/2020. There was no deficient practice identified with 42 CFR 483.73 related to E-0024 (b)(6).	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/17/2020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100180	A. BUILDING: ___ B. WING ___	11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON-HICKMAN COUNTY NURSING FACILITY	**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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments A COVID-19 Focused Infection Control Survey was initiated 11/10/2020 and concluded on 11/16/2020. The facility was found not to be in compliance pursuant to 42 CFR 483.80.	N 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/17/20