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

PRINTED: 12/04/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185315	B. WING	B. WING		11/23/2020	
NAME OF PROVIDER OR SUPPLIER  CLINTON COUNTY CARE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP 404 NORTH WASHINGTON STREET ALBANY, KY 42602			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 000	conducted on 11/23/2 to be in compliance w Control and has imple Medicare & Medicaid Centers for Disease ( (CDC) recommended	I 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 I practices to prepare for ent practice was identified.	F	000			
LABORATORY	L DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	 E	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: 100555

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

PRINTED: 12/08/2020 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	
		185315	B. WING	B. WING		11/23/2020	
NAME OF PROVIDER OR SUPPLIER  CLINTON COUNTY CARE AND REHABILITATION CENTER					STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH WASHINGTON STREET		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	-	ACTION SHOULD BE TO THE APPROPRIA		(X5) COMPLETION DATE
E 000	Initial Comments  A COVID-19 focused survey was conducte was found to be in code 483.73 Emergency P	d Emergency Preparedness d on 11/23/2020. The facility ompliance with 42 CFR reparedness related to practice was identified.					
ABORATORY	DIRECTOR'S OR PROVIDED!	SUPPLIER REPRESENTATIVE'S SIGNATUR	?F	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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Office of Inspector General

ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			
	100555	B. WING	B. WING			
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE						
CLINTON COUNTY CARE AND REHABILITATION CEN  ALBANY, KY 42602						
(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
N 000 Initial Comments						
A COVID-19 focused conducted on 11/23/2 to be in compliance po	020. The facility was found ursuant to 42 CFR 483.80.					
	COUNTY CARE AND REI  SUMMARY STA (EACH DEFICIENCY REGULATORY OR L  Initial Comments  A COVID-19 focused conducted on 11/23/2 to be in compliance pi	TOUS55  ROVIDER OR SUPPLIER  COUNTY CARE AND REHABILITATION CEN  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Initial Comments	TOUNTY CARE AND REHABILITATION CEN  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Initial Comments  ACOVID-19 focused infection control survey was conducted on 11/23/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80.	TOUNTY CARE AND REHABILITATION CEN  STREET ADDRESS, CITY, STATE, ZIP CODE  404 NORTH WASHINGTON STREET ALBANY, KY 42602  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Initial Comments  A COVID-19 focused infection control survey was conducted on 11/23/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80.	TOUNTY CARE AND REHABILITATION CEN  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Initial Comments  A. BUING	

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

TITLE (X6) DATE