DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IULTIPLE CONSTRUCTION		E SURVEY PLETED
		185326	B. WING			08	3/20/2020
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
CLINTON-HICKMAN COUNTY NURSING FACILITY				36	6 SOUTH WASHINGTON STREET		
OLINION-				CLINTON, KY 42031			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 000		ey investigating #KY31981	F	000			
	and a COVID-19 Foc Survey was initiated of concluded on 08/20/2 was unsubstantiated facility was found to b	used Infection Control on 08/19/2020 and 2020. Complaint #KY31981 with no deficiencies. The be in compliance with 42 control regulations and has ters for Medicare & MS) and Centers for Prevention (CDC) ces to prepare for					
LABORATORY	DIRECTOR'S OR PROVIDER!	SUPPLIER REPRESENTATIVE'S SIGNATU	RE		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.

PRINTED: 08/21/2020

DEPARTI	MENT OF HEALTH AN	D HUMAN SERVICES					APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 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_	WING		08/20/2020		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
CLINTON-	CLINTON-HICKMAN COUNTY NURSING FACILITY			366 SOUTH WASHINGTON STREET CLINTON, KY 42031				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIZ TAG				COMPLETION DATE	
E 000	Initial Comments		E	000				
	Survey was initiated of	020. The facility was in						
	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		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 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CC	INSTRUCTION	(X3) DATE	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING:		COMPLETED			
		B. WING		08/20/2020				
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE	·			
	HICKMAN COUNTY NU	RSING FACILITY	JTH WASHINGTON	STREET				
		CLINTO	N, KY 42031					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	F CORRECTION CTION SHOULD BE THE APPROPRIATE ICY)	BE COMPLE			
N 000	Initial Comments		N 000					
	Focused Infection Co 08/19/2020 and cond Complaint #KY3198 no deficiencies. The compliance with 42 C regulations and has Medicare & Medicaid Centers for Disease	(#KY31981) and a COVID-19 ontrol Survey was initiated on cluded on 08/20/2020. 1 was unsubstantiated with facility was found to be in CFR 483.80 infection control implemented the Centers for d Services (CMS) and Control and Prevention d practices to prepare for						

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

TITLE

(X6) DATE