CENTER	S FOR MEDICARE &	MEDICAID SERVICES					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	
		185469	B. WING			1	0/07/2020
NAME OF PI	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
CLINTON	PLACE				PADGETT DRIVE INTON, KY 42031		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 000			F	000			
	was initiated on 10/06 10/07/2020. The facil compliance with 42 C regulations and has in Medicare & Medicaid Centers for Disease C	FR 483.80 Infection Control nplemented the Centers for Services (CMS) and Control and Prevention practices to prepare for					
LABORATORY	DIRECTOR'S OR PROVIDER/S	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: 10/13/2020

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

		ID HUMAN SERVICES MEDICAID SERVICES			FOI	RM APPROVED	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		185469	B. WING		1	0/07/2020	
NAME OF PF	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, STATE, ZIP COD			
CLINTON	PLACE			106 PADGETT DRIVE CLINTON, KY 42031			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	TION SHOULD BE COMPLETION THE APPROPRIATE DATE		
E 000	Initial Comments		E 0	000			
	Survey was initiated of concluded on 10/07/2 to be in compliance w	2020. The facility was found					
		SUPPLIER REPRESENTATIVE'S SIGNATU		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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AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		100181	B. WING		10	10/07/2020	
AME OF PF	OVIDER OR SUPPLIER	ZIP CODE					
LINTON I	PLACE		GETT DRIVE				
			N, KY 42031				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CO Y MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTIO LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THI DEFICIENCY		DN SHOULD BE COMPLET IE APPROPRIATE DATE			
N 000	Initial Comments		N 000				
	was initiated on 10/0	d Infection Control Survey 6/2020 and concluded on ility was found to be in to 42 CFR 483.80.					

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

TITLE

(X6) DATE