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

PRINTED: 01/03/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	(X3) DATE SURVEY COMPLETED					
		185210	B. WING _		12/16/2020				
NAME OF PROVIDER OR SUPPLIER THE WILLOWS AT HARRODSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 180 LUCKY MAN WAY HARRODSBURG, KY 40330					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLET				
F 000	INITIAL COMMENT	rs	F 00	0					
	was initiated on 12/ 12/16/2020. The facompliance with 42 regulations and has Medicare and Medi Centers for Disease (CDC) recommend	sed Infection Control Survey 15/2020 and concluded on acility was found to be in CFR 483.80 infection control implemented the Centers for caid Services (CMS) and e Control and Prevention ed practices to prepare for							
	COVID-19. The tot	al census was 34.							
			8						
		ER/SUPPLIER REPRESENTATIVE'S SIG		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) DATE SURVEY COMPLETED		
		185210	B. WING	B. WING				12/16/2020		
NAME OF PROVIDER OR SUPPLIER THE WILLOWS AT HARRODSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 180 LUCKY MAN WAY HARRODSBURG, KY 40330			IP CODE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG					BE C	(X5) COMPLETION DATE	
E 000	Initial Comments		E 0	00	2				-22	
	Survey was initiat concluded on 12/	used Emergency Preparedness ed on 12/15/2020 and 16/2020. The facility was found ce with 42 CFR 483.73 related				*				
									¥	
				2					W.5	
	4									
ABODATORY	OIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIG	MATURE		TIT	I E	*		(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 CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING 100762 12/16/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **180 LUCKY MAN WAY** THE WILLOWS AT HARRODSBURG HARRODSBURG, KY 40330 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated on 12/15/2020 and concluded on 12/16/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The total census was 34.

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

TITLE

(X6) DATE