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

PRINTED: 10/13/2020 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	
		185474	B. WING			08/20/2020	
	OWS AT CITATION			STREET ADDRESS, CITY, STATE, 1376 SILVER SPRINGS DRIVE LEXINGTON, KY 40511	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRI		ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 000	KY#00032242 and a Infection Control Surv 08/19/2020 and conc Complaint KY#00032 with no deficiencies of to be in compliance w control regulations and Centers for Medicare (CMS) and Centers for Prevention (CDC) rec prepare for COVID-19	ey investigating Complaint COVID-19 Focused vey was initiated on luded on 08/20/2020. 242 was unsubstantiated cited. The facility was found vith 42 CFR 483.80 infection and has implemented the and Medicaid Services or Disease Control and commended practices to		DOOD 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: 101215

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

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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		
		185474	B. WING _			)8/20/202 <b>0</b>		
NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT CITATION				STREET ADDRESS, CITY, STATE, ZIP CODE  1376 SILVER SPRINGS DRIVE  LEXINGTON, KY 40511				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	( (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
E 000	Initial Comments  A COVID-19 Focused Survey was initiated concluded on 08/20/2	d Emergency Preparedness on 08/19/2020 and 020. The facility was found vith 42 CFR 483.73 related	EC	DEFICIENCY)	APPROPRIATE	DATE		

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

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) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3) DATE COME		SURVEY PLETED		
		101215	B. WING		08.	/20/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE			
THE WILLOWS AT CITATION  1376 SILVER SPRINGS DRIVE  LEXINGTON, KY 40511							
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
N 000	N 000 Initial Comments						
	KY#00032242 and a Infection Control Surv 08/19/2020 and conc Complaint KY#00032 with no deficiencies of to be in compliance profession control regulation to the Centers for Medic (CMS) and Centers for forms of the control control regulation control regulation.	vey was initiated on luded on 08/20/2020. 242 was unsubstantiated ited. The facility was found ursuant to 42 CFR 483.80 lations and has implemented care and Medicaid Services or Disease Control and commended practices to					

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TITLE (X6) DATE