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

PRINTED: 01/07/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED	
		185470				
NAME OF PROVIDER OR SUPPLIER THE WILLOWS AT HAMBURG				TREET ADDRESS, CITY, STATE, ZIP CODE 531 OLD ROSEBUD ROAD EXINGTON, KY 40509	1 12/20/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION	
E 000	Initial Comments	9	E 000			
<u>Selector</u>	Survey was initial concluded on 12/ to be in complian to E-0024 (b)(6).	tused Emergency Preparedness ted on 12/28/2020 and 28/2020. The facility was found ce with 42 CFR 483.73 related				
F 000	INITIAL COMME	NTS	F 000			
	was initiated on 1 12/28/2020. The compliance with 4 regulations and h Medicare & Medic Centers for Disea	used Infection Control Survey 2/28/2020 and concluded on facility was found to be in 42 CFR 483.80 infection control as implemented the Centers for caid Services (CMS) and use Control and Prevention anded practices to prepare for census 64.				
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ABORATORY	DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	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 CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING 101136 12/28/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2531 OLD ROSEBUD ROAD** THE WILLOWS AT HAMBURG **LEXINGTON, KY 40509** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated 12/28/2020 and concluded on 12/28/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. Total census 64.

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

TITLE

(X6) DATE