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

PRINTED: 05/28/2020 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED		
		185210	B. WING	i		0:	5/26/2020	
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 DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 000	was initiated on 05/ 05/27/2020. The fac compliance with 42 regulations and has Medicare & Medica Centers for Disease	sed Infection Control Survey (26/2020 and concluded on cility was found to be in CFR 483.80 infection control simplemented the Centers for id Services (CMS) and e Control and Prevention ed practices to prepare for	F	000				
BORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		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) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
185210			B. WING		05/26/2020	
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 180 LUCKY MAN WAY HARRODSBURG, KY 40330	1 03	120/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETION DATE
E 000	Survey was initiate concluded on 05/2	sed Emergency Preparedness d on 05/26/2020 and 7/2020. The facility was found with 42 CFR 483.73 related	E 000			
ABORATORY	DIRECTOR'S OR PROVIDE	ER/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				FORM	MAPPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DAT	(X3) DATE SURVEY COMPLETED	
		100762	8. WING		05/	05/26/2020	
NAME OF	PROVIDER OR SUPPLIER	- · · · · · · · · · · · · · · · · · · ·	ADDRESS, CITY, S				
THE WIL	LOWS AT HARRODS		CKY MAN WAY DSBURG, KY				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	CTION SHOULD BE COMPLETE O THE APPROPRIATE DATE		
N 000	Initial Comments		N 000				
	was initiated 05/26, 05/27/2020. The fa	sed Infection Control Survey /2020 and concluded on acility was found to be in nt to 42 CFR 483.80.					
			**				

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

TITLE

(X6) DATE