

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

PRINTED: 02/15/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            |                                                                                                                          |  |                                                                    |
|-------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>185470</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>02/08/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE WILLOWS AT HAMBURG</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2531 OLD ROSEBUD ROAD</b><br><b>LEXINGTON, KY 40509</b>                      |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                                         |
| F 000                                                             | INITIAL COMMENTS<br><br>An Abbreviated Survey investigating complaints<br>KY00040172, KY00041807, and KY00040652<br>and was initiated on 02/05/2024 and concluded<br>on 02/07/2024 by Sharon Miller RN NCI, a<br>representative of the Office of the Inspector<br>General, with no deficiencies cited. The<br>Ombudsman and the Department of Community<br>Based Services were notified on 02/05/2024 upon<br>entry and on 02/07/2024 upon exit. | F 000                                                                      |                                                                                                                          |  |                                                                    |

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.