

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 101338	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 03/07/2024
NAME OF PROVIDER OR SUPPLIER BLUEGRASS SENIOR LIVING SOMERSET, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 145 TOWER CIRCLE SOMERSET, KY 42503		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
P 000	Initial Comments An Abbreviated Survey investigating KY#000041671 was initiated on 03/07/2024 and concluded on 03/07/2024. The Division of Health Care determined the facility was compliant with no Regulatory Violations cited.	P 000			

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

TITLE

(X6) DATE