

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

PRINTED: 10/27/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185258</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/26/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LAKE WAY NURSING AND REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42025</b>
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(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) COMPLETION DATE
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{F 000}	<p><b>INITIAL COMMENTS</b></p> <p>Based on implementation of the acceptable POC, the facility was deemed to be in compliance 10/26/15, as alleged.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185258	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 10/26/2015
Name of Facility LAKE WAY NURSING AND REHABILITATION CENTER	Street Address, City, State, Zip Code 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42025	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0328</u> Reg. # <u>483.25(k)</u> LSC _____	Correction Completed 10/26/2015	ID Prefix <u>F0371</u> Reg. # <u>483.35(l)</u> LSC _____	Correction Completed 10/26/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By <u>ADH</u>	Date: <u>10/27/15</u>	Signature of Surveyor: <u>Deborah A. Henderson, NCHSQR</u>	Date: <u>10/27/15</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 10/1/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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NAME OF PROVIDER OR SUPPLIER  LAKE WAY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2807 MAIN STREET HWY 641 SOUTH BENTON, KY 42024
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(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) COMPLETION DATE
F 000  F 328 SS=D	<p><b>INITIAL COMMENTS</b></p> <p>A Recertification Survey was conducted on 09/29/15 through 10/01/15 with deficiencies cited at the highest Scope and Severity of an "E".</p> <p><b>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</b></p> <p>The facility must ensure that residents receive proper treatment and care for the following special services:                      injections;                      Parenteral and enteral fluids;                      Colostomy, ureterostomy, or ileostomy care;                      Tracheostomy care;                      Tracheal suctioning;                      Respiratory care;                      Foot care; and                      Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by:                      Based on observation, interview and review of facility policy, it was determined the facility failed to ensure the proper storage and handling of oxygen cylinders. Observations on 09/29/15 revealed an unsecured oxygen cylinder sitting directly on the floor in a resident room (222).</p> <p>The findings include:                      Review of the facility Safety Policy Manual, dated May 2000, revealed under the Compressed Gas Safety section included; "Compressed gas cylinders can present a variety of hazards due to their pressure and/or contents. We have therefore developed this Compressed Gas Safety Program to assist employees in understanding</p>	F 000  F 328	<p>Lake Way Nursing &amp; Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. This Plan of Correction is submitted as a written allegation of compliance. Lake Way Nursing and Rehabilitation Center's response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Lake Way Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the deficiencies through informal dispute resolution, formal appeal procedures and/or any other administrative or legal proceeding.</p> <p><b>F328</b></p> <p>Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice:                      The unsecured oxygen cylinder noted on floor of room 222B was removed from the room on 09/29/15 by Director of Nursing. DON provided another, secured, oxygen cylinder in a wheeled cart for resident use.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE Administrator DATE 10/21/15

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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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NAME OF PROVIDER OR SUPPLIER  LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2807 MAIN STREET HWY 641 SOUTH BENTON, KY 42025		
(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) COMPLETION DATE	
F 328	Continued From page 1 how to safely handle cylinders and assure adequate training in the proper storage and use of them." The Storage section included, "In storage, restrain cylinders of all sizes by straps, chains, or suitable stand to prevent them from falling".  Observation on 09/29/15 at 3:20 PM revealed an oxygen cylinder sitting unsecured on the floor near the foot of bed B. A second observation at 4:25 PM revealed the oxygen cylinder remained sitting directly on the floor and was not secured.  Interview with Licensed Practical Nurse (LPN) #1, on 09/29/15 at 4:25 PM, verified the oxygen cylinder remained sitting unsecured on the floor of room 222. LPN #1 stated that oxygen cylinders were never supposed to be unsecured. She additionally stated all staff that enter a resident's room are responsible to ensure oxygen cylinders were properly secured.  Interview on 09/30/15 at 4:10 PM with the Director of Nursing (DON) revealed she would expect oxygen cylinders to be stored secured and not left unsecured.	F 328	Every resident room, nurse's stations, therapy department as well as storage areas and offices were audited, on 10/1/15, by DON to ensure no other cylinders were unsecured. One unsecured cylinder was found and removed from the east wing nurses station.  Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:  Nursing staff will be in-serviced by Staff Facilitator Nurse, or designee, that portable oxygen cylinders are never to be placed in an unsecured manner, how to properly handle oxygen cylinders as well as potential complications that could arise from improper storage/use of oxygen cylinders. Education began on 10/1/15, and signed in-services will be completed by 10/26/15. Any employee not receiving this education during this time will be in-serviced upon their return, prior to working on the floor. Newly hired nursing staff will be in-serviced during new hire orientation.	10/26/15	
F 371 SS=E	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	Indicate how the facility plans to monitor its performance to ensure that solutions are sustained  The QI nurse or designee will audit all resident rooms, nurses' stations, therapy room, storage areas and offices for any appropriate storage of portable oxygen cylinders. This will be conducted weekly times four and then monthly times four to ensure solution is sustained. Audits will also be reviewed weekly by the Quality Improvement		

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NAME OF PROVIDER OR SUPPLIER  LAKE WAY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 841 SOUTH BENTON, KY 42025
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F 371	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policy it was determined the facility failed to ensure food was stored and served under sanitary conditions. Observation on 09/29/15 revealed a container of ham salad to be stored in the walk in refrigerator with a spreader left in the sealed container.</p> <p>Review of the Census and Condition, dated 09/29/15, revealed there were ninety-two (92) residents in the facility and, three (3) of these residents were tube fed and did not consume food items from the kitchen.</p> <p>The findings include:</p> <p>Review of the Dietary Policy titled, Housekeeping and Sanitation-Maintenance of Sanitary Conditions (Version Date: 08/2013), revealed it was the responsibility of the Food Service Manager to ensure that sanitary conditions are maintained in the storage, preparation and serving areas, as well as in the distribution of food, dish washing, pot and pan washing, etc.</p> <p>Observation in the walk in refrigerator, on 09/29/15 at 10:30 AM, revealed a large plastic container of left over ham salad with the lid on and a spreader left in the container.</p> <p>Interview with the Dietary Manager, on 09/29/15 at 10:30 AM, revealed the spreader was not supposed to be stored in the left over ham salad.</p>	F 371	<p>(QI) Committee (Administrator, QI Nurse, Director of Nursing, Director of Maintenance, Dietary Manager, Staff Facilitator Nurse and Environmental Services Director) as completed, then monthly. Any concerns will be addressed at the time of this review. A summary of audit findings will be reported to the Executive Quality Assurance Committee at Quarterly Meeting [Medical Director, Administrator, Director of Nursing, and Assistant Director of Nursing, Quality Improvement Nurse, Staff Facilitator Nurse, MDS Nurse, and Social Services Director]. Further monitoring recommendations will be made at that time, if indicated.</p> <p>F371 Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice: Dietary Manager, once made aware of food container with spreader in it on 9/29/15, immediately discarded the container of food. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>On 9/29/15, Dietary Manager audited all food storage areas for any food containers containing utensils. There were no more containers with utensils in them noted.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</p>	

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NAME OF PROVIDER OR SUPPLIER  LAKE WAY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2807 MAIN STREET HWY 641 SOUTH BENTON, KY 42025
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F 371	<p>Continued From page 3</p> <p>Interview with Dietary Aide #1, on 10/01/15 at 1:00 PM, revealed she had left the spreader in the container of left over ham salad because she had been distracted. Dietary Aide #1 stated the spreader should not have been left in the container of left over ham salad.</p> <p>Interview with the Registered Dietician, on 10/01/15 at 1:20 PM, revealed she was not sure what the policy and procedure was related to the storage of utensils and the spreader being left in the container of left over ham salad was "not best practice". The Registered Dietician additionally stated "I would not allow it and it could lead to bacteria from the handle".</p>	F 371	<p>All dietary staff will be educated by Staff Facilitator Nurse, or designee, regarding unsafe practices of storing any utensils inside a container of food and the potential complications it can impose. This education started on October 1, 2015 and signed in-services will be completed by October 26, 2015. Any employee not receiving this education during this time will be in-serviced upon their return, prior to working on the floor. Newly hired dietary staff will be in-serviced during new hire orientation.</p> <p>Indicate how the facility plans to monitor it performance to ensure that solutions are sustained</p> <p>Registered Dietitian or designee will complete weekly audits times four then monthly audits times four to ensure solution is sustained. Auditor will check for any utensils stored in food containers in the general kitchen area, food storage bins, reach in refrigerator, and walk in refrigerator and storage room. These audits will be reported to the Infection Control Committee. [Administrator, Director of Nursing, Staff Facilitator Nurse, Director of Environmental Services, and Dietary Manager] weekly and then monthly as scheduled. Any concerns identified will be addressed immediately. A summary of findings of these audits will also be reported to the Executive Quality Assurance Committee at Quarterly Meeting in January 2016 [Medical Director, Administrator, Director of Nursing, and Assistant Director of Nursing, Quality Improvement Nurse, Staff Facilitator Nurse, MDS</p>	
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NAME OF PROVIDER OR SUPPLIER  LAKE WAY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2807 MAIN STREET HWY 641 SOUTH BENTON, KY 42026
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	C		Nurse, and Social Services Director]. Further monitoring recommendations will be made at that time, if indicated.	10/26/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185258	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 2  B. WING _____		(X3) DATE SURVEY COMPLETED  R 10/22/2015
NAME OF PROVIDER OR SUPPLIER  LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2807 MAIN STREET HWY 641 SOUTH BENTON, KY 42025		
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K 000	INITIAL COMMENTS  Based on implementation of the acceptable POC, the facility was deemed to be in compliance with Life Safety Code regulations on 10/20/15, as alleged.	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X8) DATE

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<b>(Y1) Provider / Supplier / CLIA / Identification Number</b> 185258	<b>(Y2) Multiple Construction</b> A. Building <b>01 - MAIN BUILDING</b> B. Wing	<b>(Y3) Date of Revisit</b> 10/22/2015
<b>Name of Facility</b> LAKE WAY NURSING AND REHABILITATION CENTER		<b>Street Address, City, State, Zip Code</b> 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42025

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # <u>NFPA 101</u> LSC <u>K0025</u>	Correction Completed 10/20/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____	Reviewed By <u>IGH</u>	Date: <u>10/27/15</u>	Signature of Surveyor: <u>Deborah C. Henderson</u>	Date: <u>10/27/15</u>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 9/29/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right;"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO
YES	NO		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  09/29/2015
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NAME OF PROVIDER OR SUPPLIER  LAKE WAY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 67 SOUTH BENTON, KY 42025
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1978.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1978, and upgraded in 2005 with twenty-six (26) smoke detectors and no heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1978.</p> <p>GENERATOR: Type II generator installed in 1979. Fuel source is Liquid Propane.</p> <p>A standard Life Safety Code Survey was conducted on 09/29/15. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for ninety-six (96) beds with a census of ninety two (92) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000	<p>Lake Way Nursing &amp; Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. This Plan of Correction is submitted as a written allegation of compliance. Lake Way Nursing and Rehabilitation Center's response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Lake Way Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the deficiencies through informal dispute resolution, formal appeal procedures and/or any other administrative or legal proceeding.</p> <p><b>K025</b> Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>A new ceiling access to the attic area for the west wing fire/smoke barrier wall was</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X8) DATE 10/21/15
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185258	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  09/29/2015
NAME OF PROVIDER OR SUPPLIER  LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42025	
(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) COMPLETION DATE
K 000	Continued From page 1	K 000	installed by Director of Maintenance on October 17, 2015. This installation was verified by Administrator on October 20, 2015.	
K 025 SS=E	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain reasonable access to fire/smoke barrier walls in the attic area. This deficient practice affected two (2) of three (3) smoke compartments, staff, and approximately thirty-eight (38) residents. The facility has the capacity for ninety-six (96) beds with a census of ninety-two (92) on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code Survey on 09/29/15 at 2:00 PM, with the Director of Maintenance (DOM), the west wing fire/smoke barrier wall in the attic area was not reasonably accessible for inspection. The ceiling access to the attic area was not reasonable accessible due to tight</p>	K 025	<p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>On 10/15/15, Director of Maintenance inspected all other fire/smoke barrier attic areas to ensure reasonable access. No other issues were identified.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>Director of Maintenance was in-serviced by the Administrator on 10/20/15 to ensure all fire/smoke barrier attic areas have reasonable access and that these areas remain accessible.</p> <p>Indicate how the facility plans to monitor its performance to ensure that solutions are sustained</p> <p>Director of Maintenance to report to safety committee [Administrator, Director of Nursing, Staff Facilitator Nurse, Director of Environmental Services, and Quality Improvement Nurse] monthly times four</p>	

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

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K 025	<p>Continued From page 2</p> <p>framing construction and heat and air ductwork. Fire/smoke barrier walls must be reasonably accessible for inspection and maintenance purposes.</p> <p>Interview with the DOM on 09/29/15 a 2:00 PM, revealed he was not aware attic areas should be reasonably accessible for inspection and maintenance purposes.</p> <p>The census of ninety-two (92) was verified by the Administrator on 09/29/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 09/29/15.</p> <p>Reference: NFPA 101 2000 edition</p> <p>4.5.7 Maintenance. Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance.</p>	K 025	<p>regarding reasonably accessible fire/smoke barrier attic access areas and any further issues will be addressed. A summary of this auditing will also be reported to the Executive Quality Committee [Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Staff Facilitator Nurse, QI Nurse, MDS Nurse, Social Services Director] during the January 2016 Quarterly Meeting.</p>	10/20/15