

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

PRINTED: 05/15/2014  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>186258</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/01/2014</b>
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>LAKE WAY NURSING AND REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2807 MAIN STREET HWY 64 SOUTH BENTON, KY 42026</b>
---------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------

(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	INITIAL COMMENTS  An abbreviated survey (KY #21391 and KY #21429) was conducted on 03/11/14 through 03/13/14 to determine the facility's compliance with Federal requirements. KY #21391 and KY #21429 were unsubstantiated with no deficiencies cited.  After supervisory review, KY #21429 was reopened on 04/28/14 to obtain additional information, and concluded on 05/01/14. KY #21429 was substantiated with deficiencies cited at a scope and severity of a "D".	F 000	<u>RESPONSE PREFACE</u>  Lake Way 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 provision of quality of care of the residents. The Plan of Correction is submitted as a written allegation of compliance.  Lake Way's response the 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 reserves the right to submit documentation to refute any of the stated deficiencies of this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any administrative or legal proceeding.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's policy/procedure, it was determined the facility failed to have an effective system to ensure the facility's written policy and procedures were followed related to investigation of alleged violations of abuse for three residents (#1, #2, and #3). In a selected sample of four (4) residents.  The findings include:  Review of the facility's policy and procedure, titled "Abuse, Neglect, or Misappropriation of Resident	F 226	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice;  On 04/30/2014 the Administrator reported the allegations from 03/11/2014 to outside state agencies and an investigation began.  On 04/30/2014 SRNA #10 was suspended pending the investigation.	05/23/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Selma Beck TITLE: Administrator (X6) DATE: 05/23/2014

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.

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

PRINTED: 05/15/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185268</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/01/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>LAKE WAY NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2807 MAIN STREET HWY 641 SOUTH BENTON, KY 42026</b>		
(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)	(X6) COMPLETION DATE	
F 226	<p>Continued From page 1</p> <p>Property Policy", revised 05/01/13 revealed, "Residents have a right to be free from abuse, neglect, involuntary seclusion, or misappropriation of property. Any employee who witnesses or suspects that abuse, neglect, or misappropriation of property has occurred will immediately report the alleged incident to their supervisor, who immediately report the incident to the administrator. Failure to report any concern related to abuse, neglect, or misappropriation of property will result in disciplinary action and possible termination of employment. Employees accused of being directly involved in allegations of abuse, neglect of misappropriation of property will be suspended immediately from duty pending the outcome of the investigation. The Administrator is responsible to ensure that incidents, as indicated, are reported to the appropriate local/state/federal agencies, including the state Nurse Aide Registry. The Administrator is responsible to ensure that indicated corrective measures are in place. The Administrator is responsible to direct the investigative process and to ensure the appropriate agencies are notified. The Administrator will ensure that the results of the investigation are reported that the Division of Licensure and Regulation within five (5) working days.</p> <p>On 03/11/14, the State Surveyor entered the facility to investigate an allegation of abuse related to Residents #1, #2, and #3. During the course of the complaint investigation, on 03/13/14, it was noted the alleged perpetrator, State Registered Nurse Aide (SRNA) #10, was on duty.</p> <p>Interview with SRNA #10, on 4/29/14 at 10:49 AM, revealed she denied cursing at any resident,</p>	F 226	<p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice;</p> <p>On 04/30/2014 Social Service Director and Resident Service Liaison interviewed all alert and oriented residents to include Resident #2 and #3 and asked if anyone had been mean to them in any way whether it be verbally, physically, mentally etc. All residents interviewed stated no one had been mean to them in any way.</p> <p>On 04/30/2014 through 05/02/2014 interviews with staff from all departments were conducted and staff were questioned as if they had ever seen SRNA #10 be abusive in any way to any resident. Interviews revealed that no staff member had ever seen SRNA #10 to be abusive in any way.</p> <p>On 05/19/2014 all non-verbal residents skin reviews during the period of 04/30/2014 through 05/19/2014 were reviewed by the Director of Nursing and Assistant Director of Nursing for any suspicious markings and none were found.</p> <p>On 05/20/2014 the Social Service Director reviewed all residents with a BIMS score of 8 or less for any increase in behaviors or social withdrawal and none were found.</p> <p>Address what measure will be put into place or systemic changes made to ensure that the deficient practice will not recur;</p> <p>On 04/30/2014 Clinical Nurse Consultant educated Administrator, Director of</p>		

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

PRINTED: 05/15/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>186258</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/01/2014</b>
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 42026</b>		
(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 226	<p>Continued From page 2</p> <p>and revealed she had not told Resident #1, "you have a brief on, pee in it." She also denied saying to Resident #2, "your f---ing lazy," as well as Resident #3, "tell someone who cares." She revealed she was not suspended related to an investigation of the allegation and has had no abuse/neglect training since the State Surveyor was in the facility on 03/13/14. A review of SRNA #10's time sheet, dated 03/01/14 through 04/29/14, revealed she worked in the facility throughout the entire time frame.</p> <p>Interview with the Social Service Director (SSD), on 04/30/14 at 9:05 AM, revealed the process was, once an allegation of abuse was made, the Administrator or the Director of Nursing (DON) were to immediately initiate an investigation. The SSD interviewed all interviewable residents and all staff pertinent to the allegation. It was the responsibility of the Administrator or DON to suspend the alleged perpetrator pending the outcome of the investigation.</p> <p>Interview with the DON, on 04/29/14 at 11:55 AM, revealed "we did not suspend SRNA #10. An investigation was conducted in conjunction with both State Agencies [Department of Community Based Services (DCBS) and Office of Inspector General (OIG)], not prior to the State Agencies' entry to the facility, and we unsubstantiated the allegation."</p> <p>Interview with the Administrator, on 04/30/14 at 8:15 AM, revealed she was "unable to provide evidence of an investigation related to the allegation, because it was not typical practice to investigate once the State Agencies entered the facility to investigate an allegation. Once the State Agencies arrived, I felt we were a part of the</p>	F 226	<p>Nursing, Assistant Director of Nursing and Staff Facilitator on the abuse policy and also on completing an investigation even when state agencies bring the allegations to facility.</p> <p>Beginning on 04/29/2014 and concluding on 05/02/2014 all staff were re-educated on abuse reporting and a focus on verbal abuse definition.</p> <p>Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.</p> <p>Social Service Director and Resident Service Liaison will interview alert and oriented monthly x 3 months for any concerns with care and feelings of mistreatment. Results of these questions will be reviewed at the next day department head meeting where members of the QAPI team will be present and at the quarterly Executive QAPI meeting.</p> <p>Social Services will monitor with quarterly assessments residents with a BIMS score of 3 or less for any increase in behaviors such as fearfulness and withdrawal and report changes to Director of Nursing and Administrator.</p> <p>Staff Facilitator will quiz staff on abuse and abuse reporting monthly x 3 months. Results of these questions will be reviewed at the next day department head meeting where members of the QAPI team will be present and at the quarterly Executive QAPI meeting.</p>		

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

PRINTED: 05/15/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 05/01/2014
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 42026		
(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 226	Continued From page 3 Investigation. We made copies of the information provided to the State Agencies, reviewed it, and we interviewed the same residents the State Agencies interviewed." Further interview with the Administrator, on 05/01/14 at 8:13 AM, revealed "we spoke with Residents #1, #2, and #3, and each resident denied the allegation. SRNA #10 was allowed to work because there was no feeling of threat to Residents #1, #2, or #3." She further stated, "I have not been used to initiating a formal investigation when the State Agencies were in the facility; however, we did not follow our Abuse/Neglect policy/procedure, and we have no evidence of an investigation."	F 226	The Executive QAPI Committee with the Medical Director will review quarterly QAPI information and will validate the facilities progress in correction of deficient practices or identify concerns.		
F 490 SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's policy/procedure, it was determined the facility failed to ensure the facility was administered in a manner that enables it to use its resources effectively and efficiently to attain the highest practicable physical, mental and psychosocial well-being of each resident. The facility failed to ensure a safe environment by allowing State Registered Nurse Aide (SRNA) #10 to continue to work with residents after an allegation of abuse was reported.	F 490	F490 Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice;  On 04/30/2014 the Administrator reported the allegations from 03/11/2014 to outside state agencies and an investigation began.  On 04/30/2014 SRNA #10 was suspended pending the investigation.  Address how the facility will identify other residents having the potential to be affected by the same deficient practice;  On 04/30/2014 Social Service Director and Resident Service Liaison interviewed all alert and oriented residents to include Resident #2 and #3 and asked if anyone had been mean to them in any way whether it be verbally, physically, mentally etc. All residents interviewed stated no one had been mean to them in any way.  On 04/30/2014 through 05/02/2014 interviews with staff from all departments were conducted and staff were questioned as	05/23/2104	

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

PRINTED: 05/15/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 05/01/2014
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 42026		
(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 490	Continued From page 4  The findings include:  Review of the facility's policy and procedure, titled "Abuse, Neglect, or Misappropriation of Resident Property Policy", revised 05/01/13 revealed, "The Administrator is responsible to ensure that incidents, as indicated, are reported to the appropriate local/state/federal agencies, including the state Nurse Aide Registry. The Administrator is responsible to ensure that indicated corrective measures are in place. The Administrator is responsible to direct the investigative process and to ensure the appropriate agencies are notified. The Administrator will ensure that the results of the investigation are reported that the Division of Licensure and Regulation within five (5) working days.  On 03/11/14, the State Surveyor entered the facility to investigate an allegation of abuse related to Residents #1, #2, and #3. During the course of the complaint investigation, on 03/13/14, it was noted the alleged perpetrator, SRNA #10, was on duty.  Interview with SRNA #10, on 4/29/14 at 10:49 AM, revealed she denied cursing at any resident, and revealed she had not told Resident #1, "you have a brief on, pee in it." She also denied saying to Resident #2, "your f---ing lazy," as well as Resident #3, "tell someone who cares." She revealed she was not suspended related to an investigation of the allegation and has had no abuse/neglect training since the State Surveyor was in the facility on 03/13/14. A review of SRNA #10's time sheet, dated 03/01/14 through 04/29/14, revealed she worked in the facility throughout the entire time frame.	F 490	f they had ever seen SRNA #10 be abusive in any way to any resident. Interviews revealed that no staff member had ever seen SRNA #10 to be abusive in any way.  On 05/19/2014 all non-verbal residents skin reviews during the period of 04/30/2014 through 05/19/2014 were reviewed by the Director of Nursing and Assistant Director of Nursing for any suspicious markings and none were found.  On 05/20/2014 the Social Service Director reviewed all residents with a BIMS score of 3 or less for any increase in behaviors or social withdrawal and none were found.  Address what measure will be put into place or systemic changes made to ensure that the deficient practice will not recur;  On 04/30/2014 Clinical Nurse Consultant educated Administrator, Director of Nursing, Assistant Director of Nursing and Staff Facilitator on the abuse policy and also on completing an investigation even when state agencies bring the allegations to facility.  Beginning on 04/29/2014 and concluding on 05/02/2014 all staff were re-educated on abuse reporting and a focus on verbal abuse definition.  Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.		

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

PRINTED: 05/15/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 05/01/2014
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 42026		
(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 490	Continued From page 5  Interview with the Adminstrator, on 04/30/14 at 8:15 AM, revealed she was "unable to provide evidence of an investigation related to the allegation, because it was not typical practice to investigate once the State Agencies (DCBS and OIG) entered the facility to investigate an allegation. Once the State Agencies arrived, I felt we were a part of the investigation. We made copies of the information provided to the State Agencies, reviewed it, and we interviewed the same residents the State Agencies interviewed." Further interview with the Administrator, on 05/01/14 at 8:13 AM, revealed "we spoke with Residents #1, #2, and #3, and each resident denied the allegation. SRNA #10 was allowed to work because there was no feeling of threat to Residents #1, #2, or #3." She further stated, "I have not been used to initiating a formal investigation when the State Agencies were in the facility; however, we did not follow our Abuse/Neglect policy/procedure, and we have no evidence of an investigation."	F 490	Social Service Director and Resident Service Liaison will interview alert and oriented monthly x 3 months for any concerns with care and feelings of mistreatment. Results of these questions will be reviewed at the next day department head meeting where members of the QAPI team will be present and at the quarterly Executive QAPI meeting.  Social Services will monitor with quarterly assessments residents with a BIMS score of 8 or less for any increase in behaviors such as fearfulness and withdrawal and report changes to Director of Nursing and Administrator.  Staff Facilitator will quiz staff on abuse and abuse reporting monthly x 3 months. Results of these questions will be reviewed at the next day department head meeting where members of the QAPI team will be present and at the quarterly Executive QAPI meeting.  The Executive QAPI Committee with the Medical Director will review quarterly QAPI information and will validate the facilities progress in correction of deficient practices or identify concerns.		