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

PRINTED: 12/09/2020 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | () | (X3) DATE SURVEY COMPLETED | |
|--|--|--|--|---|----|-------------------------------|--|
| | | 185258 | B. WING | | | 12/08/2020 | |
| 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 CORRECT X (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | | (X5) COMPLETION DATE | |
| | was initiated on 12/07 12/08/2020. The facili compliance with 42 C regulations and has ir Medicare & Medicaid Centers for Disease C (CDC) recommended COVID-19. Total cens | d Infection Control Survey 7/2020 and concluded on ty was found to be in FR 483.80 infection control mplemented the Centers for Services (CMS) and Control and Prevention practices to prepare for | FC | TITLE | | (X6) DATE | |

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

(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.

Facility ID: 100514

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| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPL | (X3) DATE SURVEY COMPLETED | |
|---|-------------------------------|--|
| 185258 B. WING 12/0 | 12/08/2020 | |
| 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 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| E 000 A COVID-19 Focused Emergency Preparedness Survey was initiated on 12/07/2020 and concluded on 12/08/2020. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6). | | |

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.

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Office of Inspector General

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING: | | | (3) DATE SURVEY COMPLETED | | | | | | | |
|---|---|---|---------------------|---|--------------------------------|--------------------------|--|--|--|--|--|--|
| | | 100514 | B. WING | | 12 | /08/2020 | | | | | | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | | | | | | | |
| LAKE WAY NURSING AND REHABILITATION CENTER 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42025 | | | | | | | | | | | | |
| (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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE | | | | | | |
| N 000 | N 000 Initial Comments | | | | | | | | | | | |
| N 0000 | A COVID-19 Focused was initiated 12/07/20 | I Infection Control Survey 220 and concluded on lity was found to be in to 42 CFR 483.80. | N 000 | | | | | | | | | |
| | | | | | | | | | | | | |

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

TITLE (X6) DATE