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

PRINTED: 01/07/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		185258	B. WING	B. WING		12/29/2020	
NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIF 2607 MAIN STREET HWY 641 SOU BENTON, KY 42025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIA		
F 000	initiated on 12/28/202 12/29/2020. The facil compliance with 42 C and has implemented and Medicaid Service Disease Control and recommended practic 19. Total Census 56.	n Control Survey was 20 and concluded on lity was found to be in CFR 483.80 Infection Control d the Centers for Medicare es (CMS) and the Center for Prevention (CDC) ces to prepare for COVID		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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
185258 B. V			B. WING _	B. WING			12/	29/2020
NAME OF PROVIDER OR SU		BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42025				
PREFIX (EACI	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
Survey was concluded	9 Focuse s initiated on 12/29/2 npliance v	d Emergency Preparedness on 12/28/2020 and 2020. The facility was found with 42 CFR 483.73 related	E	000				

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.

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

TITLE

(X6) DATE

PRINTED: 01/07/2021 FORM APPROVED

Office of Inspector General

NAME OF PROVIDER OR SUPPLIER THERET ADDRESS, CITY, STATE, ZIP CODE 2807 MAIN STREET HWY 641 SOUTH BETTON, KY 4205 (A4)ID, PRETTX 1AC Initial Comments A COVID 19 Infection Control Survey was initiated on 12/28/2020 and concluded on 12/28/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						DATE SURVEY COMPLETED		
LAKE WAY NURSING AND REHABILITATION CENTER 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42025 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) N 000 Initial Comments A COVID 19 Infection Control Survey was initiated on 12/28/2020 and concluded on 12/29/2020. The facility was found to be in	100514			B. WING			12/29/2020		
LAKE WAY NURSING AND REHABILITATION CENTER BENTON, KY 42025 (X4) ID PREFIX TAG N 000 Initial Comments A COVID 19 Infection Control Survey was initiated on 12/28/2020 and concluded on 12/29/2020. The facility was found to be in	NAME OF PI	ROVIDER OR SUPPLIER							
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A COVID 19 Infection Control Survey was initiated on 12/28/2020 and concluded on 12/29/2020. The facility was found to be in	PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	COMPLETE	
initiated on 12/28/2020 and concluded on 12/29/2020. The facility was found to be in	N 000	Initial Comments			N 000				
	N 000	A COVID 19 Infection Control Survey was initiated on 12/28/2020 and concluded on 12/29/2020. The facility was found to be in							

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

TITLE (X6) DATE