

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

PRINTED: 04/11/2012  
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 03/28/2012
--	--	--	---

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 000	INITIAL COMMENTS  An abbreviated survey (KY #18013) was conducted on 03/27/12 through 03/28/12 to determine compliance with Federal requirements. KY #18013 was substantiated with deficiencies cited at the highest scope and severity of a "D."  F 279 SS=D 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to develop a comprehensive care plan for each resident which included	F 000	<u>RESPONSE PREFACE</u>  Lake Way Nursing and 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 provision of quality of care of the residents. The Plan of Correction is submitted as a written allegation of compliance.  Lake Way Nursing and Rehabilitation Center'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 Nursing and Rehabilitation Center reserves the right 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.	
-------	--	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Memo Bryant</i>	TITLE <i>Administrator</i>	(X6) DATE 4/20/12
---	-------------------------------	----------------------

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: 04/11/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/28/2012
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 279	Continued From page 1 measurable objectives and timetables to meet a resident's needs related to the management of aggressive behaviors toward other residents for two residents (#3 and #4), in the selected sample of five residents.  Findings include:  A review of the facility's policy/procedure, "Resident Care Plan," revised 09/19/11, revealed "any new problem or need of the resident which was identified between his/her scheduled care plan review will be addressed on the care plan by the concerned disciplines."  1. A record review revealed the facility admitted Resident #4 on 06/17/06 with a diagnosis to include Vascular Dementia. A review of the quarterly Minimum Data Set (MDS), dated 01/17/12, revealed the facility identified Resident #4 as moderately cognitively impaired.  A review of the facility's Investigative Report, dated 03/06/12, revealed Resident #4 "slapped" another resident in the face, on 03/06/12 at approximately 1:50 PM. There was no evidence of a care plan to address the management of Resident #4's physically aggressive behaviors.  2. A record review revealed the facility admitted Resident #3 on 11/23/04 with diagnoses to include Schizophrenia, Senile Dementia, and Psychosis. A review of the quarterly MDS, dated 01/25/12, revealed the facility identified Resident #1 as severely cognitively impaired.  A review of the facility's Investigative Report, dated 03/12/12, revealed Resident #3 hit another	F 279	The care plan was revised for Resident #3 on 4/10/12 and Resident #4 on 3/30/12 by the MDS Coordinator to include individualized interventions to manage history of physically aggressive behaviors.  Nursing progress notes completed in the last 3 months for current residents were audited by Administrative staff including Administrator, DON, ADON, QI Nurse, MDS Nurses and Admission Coordinator and completed on 04/20/2012 to identify any other residents who had been identified with physically aggressive behaviors to ensure that a care plan has been developed and revised with individualized interventions to prevention reoccurrences.  Nursing progress notes will be read by the Administrative Nursing Staff including Administrator, DON, ADON, QI Nurse, MDS Nurses, Social Worker, and Admission Coordinator daily Monday thru Friday to identify changes in condition and/or behaviors that may need to be added to the care plan.	

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

PRINTED: 04/11/2012  
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 03/28/2012
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	
F 279	Continued From page 2 resident on the left forearm, on 03/12/12 at approximately 1:15 PM. There was no evidence of a care plan to address the management of Resident #3's physically aggressive behaviors.  An interview with the Social Services Designee, on 03/28/12 at 3:50 PM, revealed she does not always know the details of resident to resident altercations that occur in the facility. She revealed the MDS nurse was responsible for the initiation and revision of the behavior care plans.  An interview with the MDS Coordinator, on 03/28/12 at 2:45 PM, revealed she should have initiated a care plan for Resident #3 and Resident #4, after they were physically aggressive towards another resident in the facility. She revealed their behaviors had the potential to occur again.  An interview with the Director of Nursing (DON), on 03/28/12 at 4:10 PM, revealed all resident to resident altercations were discussed in the morning meeting and all disciplines were made aware. She expected the MDS nurse to initiate a care plan as needed.	F 279	Administrative Nursing Staff including the Administrator, DON, QI Nurse, Social Worker, Admission Coordinator and MDS Nurse were re-educated on 04/18/2012 by Nurse Consultant on developing and revising the care plan, including addressing the management of aggressive behaviors, related to resident to resident altercations. Resident to resident altercations will continue to be discussed in the morning meeting by the Interdisciplinary team including the Administrator, DON, QI Nurse, Social Worker and MDS Nurse. Care plans will be reviewed and revised as indicated.  QI audits will be conducted weekly X4 then monthly by the QI Nurse of		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending	F 280	any residents reported with resident to resident incidents, including physically aggressive behaviors, to ensure that care plans have been updated & revised to address the management of these behaviors. The results of these audits will be reviewed with the DON and Administrator with any further actions taken as indicated.	05/01/12	

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

PRINTED: 04/11/2012  
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 03/28/2012
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	
F 280	<p>Continued From page 3</p> <p>physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure each resident's care plan was revised for two residents (#1 and #2), in the selected sample of five residents.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Resident Care Plan," revised 09/19/11, revealed "modification of the care plan would be done at least quarterly and as needed for residents under the direction of the RN Coordinator/designee."</p> <p>1. A record review revealed the facility admitted Resident #1 on 05/05/08 with diagnoses to include Alzheimer's Dementia, Psychosis, Dementia with Behavioral Disturbances, and Psychotic Disorder with Hallucinations. A review of the quarterly Minimum Data Set (MDS), dated 03/13/12, revealed the facility identified Resident #1 as severely cognitively impaired.</p> <p>A review of three Investigative Reports, dated</p>	F 280	<p>The care plan for Resident #1 was revised on 3/27/2012 by the MDS Nurse to include 1:1 observation. The care plan for Resident #2 was revised on 04/12/2012 by the MDS Nurse to include re-direction of others when they get too close to the residents personal space.</p> <p>A QI audit was conducted by 04/20/2012 by Administrative Staff including Administrator, DON, ADON, QI Nurse, MDS Nurses, Social Worker, and Admission Coordinator, reading progress notes of current to identify that each resident's care plan has been revised as indicated based on changes in condition documented in the nurse's progress notes and MD orders. Changes have been made as indicated. Residents will continue to have a care plan developed &amp; revised as indicated by the MDS Nurse based on individual needs identified through the RAI process, documented changes in condition &amp; MD orders.</p> <p>Nursing progress notes will be read by the Administrative Nursing Staff including Administrator, DON,</p>		

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

PRINTED: 04/11/2012  
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 03/28/2012
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 280	<p>Continued From page 4</p> <p>03/06/12 and 03/12/12, revealed Resident #1 was "slapped" in the face by another resident, on 03/06/12 at 1:50 PM. Resident #1 was hit on the forearm by another resident, on 03/12/12 at 1:15 PM. Additionally, Resident #1 was hit in the stomach, on 03/12/12 at 5:30 PM. An interview with the Director of Nursing (DON), on 03/28/12 at 4:10 PM, revealed Resident #1 was currently on "one to one" supervision with a staff member, except while sleeping.</p> <p>A review of the resident's care plan revealed no revisions were made to include the resident being on increased supervision.</p> <p>An interview with the MDS Coordinator, on 03/28/12 at 2:45 PM, revealed she should have revised the care plan for Resident #1 to include "one to one" supervision.</p> <p>2. A record review revealed the facility admitted Resident #2 on 01/01/08 with diagnoses to include Senile Dementia, Panic Disorder, and Anxiety. A review of the quarterly MDS, dated 02/28/12, revealed the facility identified Resident #2 as moderately cognitively impaired.</p> <p>A review of the Comprehensive Care Plan, dated 06/28/11, revealed Resident #2 was aggressive or combative at times.</p> <p>A review of the Investigative Report, dated 03/12/12, revealed Resident #2 hit Resident #1 in the stomach, on 03/12/12 at approximately 5:30 PM; however, after the resident to resident altercation, there was no evidence of any new interventions put into place on the Comprehensive Care Plan, on 03/12/12.</p>	F 280	<p>ADON, QI Nurse, MDS Nurses, Social Worker, and Admission Coordinator daily, Monday thru Friday, to identify changes in condition and/or behaviors that may need to be added to the care plan.</p> <p>Administrative Nursing including the Administrator, DON, ADON, QI Nurse, Social Worker, Admissions Coordinator and MDS Nurse were re-educated on .04/18/2012 by the Nurse Consultant on reviewing the nursing progress notes and MD orders daily, Monday thru Friday, to identify changes in condition and behaviors and developing and revising the care plan as indicated based on individual needs identified.</p> <p>A QI audit will be conducted weekly X4, then monthly by the QI Nurse to identify that revisions have been made to the care plan based on documented changes in the nursing progress notes and MD orders. The results of theses audits will be reviewed with the DON and Administrator with further actions taken as indicated.</p>	05/01/12	

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

PRINTED: 04/11/2012  
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 03/28/2012
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	
F 280	Continued From page 5  An interview with the MDS Coordinator, on 03/28/12 at 2:45 PM, revealed a new intervention should have been completed on the resident's care plan, especially after an altercation with another resident.  An interview with the DON, on 03/28/12 at 4:10 PM, revealed she expected the staff to review the care plan after a resident to resident altercation and add a new intervention.	F 280			