DIVISION OF HEALTH CARE
PACKET PROCESS LIST

FACILITY: ____ CITY: ________

LEVEL OF CARE: ______________________ SURVEY DATE(S): _______________

SURVEY TYPE: INITIAL RELIC. RECERT. REVISIT OTHER

COMPLAINT #_______________ PRIORITY: 1 2 3 4

***LIST ENTRANCE TIME/DATE IF OFF-HOURS SURVEY:__________________ (M E W H)**
***NURSE AIDE TRAINING PROGRAM: YES NO**

TEAM:____ SECRETARY:______________

ACTION			INITIALS	DATE
Packet Completed:	Deficiency(ies)?	YES NO	________	_______
	Life Safety Code Tags included	YES NO		
RPM Review			________	_______
Packet to Secretary			________	_______
SoD to Facility			________	_______
PoC Received and Copy to Coordinator			________	_______
POC Acceptable:	YES NO		________	_______
Provider Notified:	by__________on			
POC Returned to Facility			________	_______
2nd POC Received and Copy to Coordinator			________	_______
2nd POC Acceptable:	YES NO		________	_______
Provider Notified:	by__________on			
Revisit Required:	YES NO		________	_______
Revisit Completed:	Deficiency(ies) YES NO		________	_______
Revisit SoD to Facility			________	_______
PoC Received and Copy to Coordinator			________	_______
PoC Acceptable:	YES NO		________	_______
Provider Notified:	by__________on			
2nd Revisit Required:		YES NO	________	_______
2nd Revisit Completed:	Deficiency(ies)	YES NO	________	_______
Packet Completed			________	_______

Highest Scope/Severity _________ Opportunity to Correct or No Opportunity to Correct (OTC or NOTC)
SQC___.13 ___.15 ___.25 (X areas of SQC)------(Complete form HCFA-673 if SQC identified)
RPM/C.O. notified of SQC _______________ Doctors/Board Letters Mailed-Ann Notified of SQC
Citation Issued: TYPE A or TYPE B **(Type A stamped & faxed to Attorney General's Office __________)**

PoC Due _____________ Latest PoC Date _____________ Date to be Corrected:

IDR Requested ______________ IDR Scheduled _____________ IDR Held
Changes to SoD? YES NO IDR SoD/Notice _____________ IDR PoC Due
IDR PoC Received ______________ PoC Acceptable? YES NO Provider Notified: by ________on
PACKET TO C.O. ______________ PACKET TO R.O. _______________ 462L faxed to C.O.
______________ _______________ 1539 faxed to C.O.

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: B4RZ11
Facility ID: 100514

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **185258**

2. STATE VENDOR OR MEDICAID NO. (L2) **12501029**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKE WAY NURSING AND REHABILITATION CENTER**
(L4) **2607 MAIN STREET HWY 641 SOUTH**
(L5) **BENTON, KY** (L6) **42025**

4. TYPE OF ACTION: **6** (L8)
1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 05 HHA, 09 ESRD, 13 PTIP, 22 CLIA, 02 SNF/NF/Dual, 06 PRTF, 10 NF, 14 CORF, 03 SNF/NF/Distinct, 07 X-Ray, 11 ICF/IID, 15 ASC, 04 SNF, 08 OPT/SP, 12 RHC, 16 HOSPICE

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

FISCAL YEAR ENDING DATE: (L35)

11. LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12. Total Facility Beds **96** (L18)

13. Total Certified Beds **96** (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	96			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): **YES** (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Terri Darlene Myers, RN, NCI /lef 10/22/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00000** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

Paul Thomas Shepard (lkw74-admin@lakewaycare.com)

Facility Phone: (270) 527-3296

This facility utilizes the ePOC system.

The last Standard Survey concluded on 10/08/2020.

An Abbreviated Survey investigating KY00033541, KY00033983 and a COVID-19 Focused Infection Control Survey was initiated on 07/14/2021 and concluded on 07/15/2021. KY00033541, KY00033983 were unsubstantiated with no deficiencies cited. The facility was found not to be in compliance with 42 CFR 483.80 infection control regulations and has not implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19 with F880 cited at a Scope and Severity of an "D". Total Census 62.

An SoD was issued 07/29/2021.

The following remedies have been imposed by the state agency:
*Directed Plan of Correction effective 08/13/2021.
*Discretionary Denial of payment for new admissions effective 09/12/2021.

Therefore the following remedies are recommended to CMS:
*A Per Instance civil money penalty of $15,000.
*Termination of the provider agreement if substantial compliance has not been achieved by 01/15/2022.

A PoC was received 08/09/2021. On 08/10/2021 after submission of PoC, Administrator notified SA of needing to change some dates in POC. Received revised PoC 08/11/2021. The PoC received 08/11/2021 was determined to be acceptable, alleging compliance 08/22/2021, pending onsite revisit.

An onsite revisit was condcuted 09/01/2021 in conjunction with a Focused Infection Control Survey. It was determined the facility remained out of compliance, with F880 being recited at a S/S of "D".

SoDs were issued 09/14/2021.

The following remedies have been imposed by the state agency:
*Directed Plan of Correction effective 09/29/2021.
*Discretionary Denial of payment for new admissions effective 09/12/2021.

Therefore the following remedies are recommended to CMS:
*A Per Instance civil money penalty of $15,000.
*Termination of the provider agreement if substantial compliance has not been achieved by 01/15/2022.

An acceptable PoC was received 09/21/2021 for the 09/01/2021 Focused Infection Control Survey, alleging compliance 10/08/2021, pending onsite revisit.

An acceptable PoC was received 09/23/2021 for the 09/01/2021 revisit to the 07/15/2021 Focused Infection Control Survey, alleging compliance 10/08/2021, pending onsite revisit.

A COVID-19 Focused Infection Control Survey was initiated and concluded on 10/12/2021. There was no deficient practice identified at 42 CFR 483.80 Infection Control regulations and the facility has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 63.

An onsite revisit was conducted 10/12/2021, with the facility determined to be in substantial compliance on 10/08/2021, as alleged.

Therefore the final remedy recommendations are:
*Directed Plan of Correction effective 09/29/2021.
*Discretionary Denial of payment for new admissions effective 09/12/2021 thorugh 10/07/2021.
*A Per Instance civil money penalty of $15,000.
*Termination of the provider agreement effective 01/15/2022, rescinded, due to the faclity being in compliance 10/08/2021.

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

Date Printed: 10/12/2021
Unit: All
Floor: All

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No.	Medicare F75	Medicaid F76	Other F77	Total Residents F78
185258	4	50	9	63

ADL	Independent	Assist of One or Two Staff	Dependent
Bathing	F79 1	F80 44	F81 18
Dressing	F82 1	F83 51	F84 11
Transferring	F85 14	F86 30	F87 19
Toilet Use	F88 9	F89 38	F90 16
Eating	F91 37	F92 17	F93 9

A. Bowel/Bladder Status

F94 5 With indwelling or external catheter

F95 Of the total number of residents with catheters, how many were present on admission 3?

F96 26 Occasionally or frequently incontinent of bladder

F97 24 Occasionally or frequently incontinent of bowel

F98 9 On urinary toileting program

F99 3 On bowel toileting program

B. Mobility

F100 8 Bedfast all or most of time

F101 41 In a chair all or most of time

F102 7 Independently ambulatory

F103 7 Ambulation with assistance or assistive device

F104 0 Physically restrained

F105 Of the total number of residents with restraints, how many were admitted or readmitted with orders for restraints 0?

F106 15 With contractures

F107 Of the total number of residents with contractures, how many had a contracture(s) on admission 9?

C. Mental Status

F108-114 - indicate the number of residents with:

F108 2 Intellectual and/or developmental disability

F109 3 Documented signs and symptoms of depression

F110 24 Documented psychiatric diagnosis (exclude dementias and depression)

F111 20 Dementia: (e.g., Lewy-Body, vascular or Multi-infarct, mixed, frontotemporal such as Pick's disease; and dementia related to Parkinson's or Creutzfeldt-Jakob diseases), or Alzheimer's Disease

F112 1 Behavioral healthcare needs

F113 Of the total number of residents with behavioral healthcare needs, how many have an individualized care plan to support them 1?

F114 0 Receiving health rehabilitative services for MI and/or ID/DD

D. Skin Integrity

F115-118 - indicate the number of residents with:

F115 3 Pressure ulcers (exclude Stage 1)

F116 Of the total number of residents with pressure ulcers excluding Stage 1, how many residents had pressure ulcers on admission 3?

F117 28 Receiving preventive skin care

F118 0 Rashes

Form CMS-672 (05/12)

Date Printed: 10/12/2021
Unit: All
Floor: All

E. Special Care

F119-132 - indicate the number of residents receiving:

- F119 1 Hospice care
- F120 0 Radiation therapy
- F121 0 Chemotherapy
- F122 1 Dialysis
- F123 0 Intravenous therapy, IV nutrition, and/or blood transfusion
- F124 6 Respiratory treatment
- F125 0 Tracheostomy care
- F126 2 Ostomy care
- F127 0 Suctioning
- F128 16 Injections (exclude vitamin B12 injections)
- F129 0 Tube feedings
- F130 17 Mechanically altered diets including pureed and all chopped food (not only meat)
- F131 10 Rehabilitative services (Physical therapy, speech-language therapy, occupational therapy, etc.) Exclude health rehabilitation for MI and/or ID/DD
- F132 13 Assistive devices while eating

F. Medications

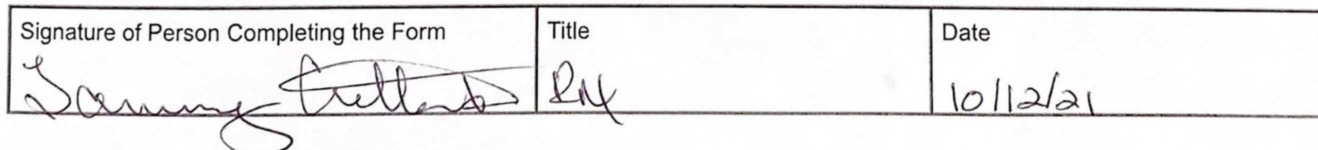
F133-139 - indicate the number of residents receiving:

- F133 43 Any psychoactive medication
  - F134 14 Antipsychotic medications
  - F135 15 Antianxiety medications
  - F136 42 Antidepressant medications
  - F137 2 Hypnotic medications
- F138 5 Antibiotics
- F139 21 On pain management program

G. Other

- F140 4 With unplanned significant weight loss/gain
- F141 0 Who do not communicate in the dominant language of the facility (include those who use American sign language)
- F142 0 Who use non-oral communication devices
- F143 16 With advance directives
- F144 32 Received influenza immunization
- F145 39 Received pneumococcal vaccine

I certify that this information is accurate to the best of my knowledge.



Signature of Person Completing the Form	Title	Date
[signature]	RN	10/12/21

TO BE COMPLETED BY SURVEY TEAM

- F146 Was ombudsman notified prior to survey? ✓ Yes __ No
- F147 Was ombudsman present during any portion of the survey? __ Yes ✓ No
- F148 Medication error rate NA %

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

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No.	Medicare	Medicaid	Other	Total Residents
185258	12 F75	43 F76	9 F77	64 F78

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F142 0 Who use non-oral communication devices

F143 16 With advance directives

F144 32 Received influenza immunization

F145 39 Received pneumococcal vaccine

I certify that this information is accurate to the best of my knowledge.

Signature of Person Completing the Form	Title	Date
Tammy Crittenden	[illegible]	9/01/21

TO BE COMPLETED BY SURVEY TEAM

F146	Was ombudsman office notified prior to survey?	X Yes	___ No
F147	Was ombudsman present during any portion of the survey?	___ Yes	X No
F148	Medication error rate N/A %		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185258	A. BUILDING ______ B. WING ______	R **10/12/2021**

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	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 Onsite Revisit conducted 10/12/2021 for the 07/15/2021 and 09/01/2021 surveys, determined the facility had achieved substantial compliance 10/08/2021, as alleged. A COVID-19 Focused Infection Control Survey (FICS) was conducted in conjunction with the onsite revisit. The facility was found to be in compliance with 42 CFR 483.80 Infection Control and has implemented the Centers for Medicare and Medicaid Services (CMS) and the Center for Disease Control and Prevention (CDC) recommended practices to prepare for COVID 19. Census 63.	{F 000}		

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.

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
185258	A. Building B. Wing	10/12/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE WAY NURSING AND REHABILITATION CENTER	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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 10/08/2021	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 STATE AGENCY ☐	REVIEWED BY (INITIALS) DF /lcf	DATE 10/22/2021	SIGNATURE OF SURVEYOR Terri Darlene Myers, RN, NCI /lcf	DATE 10/22/2021
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/1/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

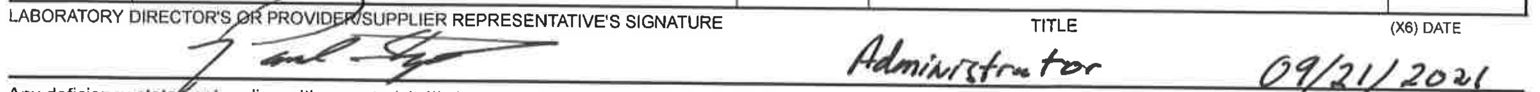
PRINTED: 09/14/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185258	A. BUILDING ______ B. WING ______	09/01/2021

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	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 Onsite Revisit conducted on 09/01/2021 for the 07/15/2021 survey and a COVID-19 Focused Infection Control Survey (FICS) were conducted on 09/01/2021. The survey determined the facility remained out of compliance at a Scope and Severity of a "D". The facility was found in violation of 42 CFR 483.80 infection control regulations and had not implemented the Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total Census was 64.	F 000	**The preparation and execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. The facility reserves its right to dispute the facts and conclusions in a forum if necessary. This Plan of Correction is prepared and executed solely because it is required by Federal and State law.**	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880	**F 880** **Infection Prevention & Control** **Criteria 1**: There were no residents affected as the nurse was at the nursing station behind a plexiglass barrier. LPN 1 received counselling, was re-educated on the facility PPE policy and is wearing PPE according to policy. **Criteria 2**: No residents were identified	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 09/21/2021



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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185258	A. BUILDING ______ B. WING ______	09/01/2021

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	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 880	Continued From page 1 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880	**Criteria 3**: All staff will receive in-service education on facility PPE policy and will watch the training video "Use Personal Protective Equipment Correctly for COVID-19" located at www.youtube.com/yytatw9yav4. This training will be conducted by the Director of Nursing and the Infection Preventionist between 09/23/2021-10/07/2021 with an attestation of completion. **Criteria 4**: The Director of Nursing, Infection Preventionist, ADON, SDC, or Unit Managers will conduct Infection Control Audits daily X 2 weeks and then weekly X 2 months to ensure compliance with Infection Prevention and Control regulations. The results of the audits will be taken to the monthly QAPI committee for three months. The QAPI committee will review the results for trends and make recommendations. **Criteria 5**: October 8, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185258	A. BUILDING ______ B. WING ______	09/01/2021

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	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 880	Continued From page 2 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, and the Centers for Disease and Prevention (CDC) guidelines it was determined the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases, including COVID-19. Observation on 09/01/2021 at 2:40 PM, revealed Licensed Practical Nurse (LPN) #1 sitting at the nursing station with her face mask underneath her chin, leaving her nose and mouth not covered. The findings include: Review of the facility's policy titled, "Guidelines on Latest Approach to PPE Use During COVID-19 Pandemic", updated 06/21/2021, revealed employees should wear masks when entering and leaving the facility. Further review of the policy revealed staff must wear face mask protection at all times. Observation on 09/01/2021 at 2:40 PM, on the East Unit, revealed LPN #1 had her mask pulled down underneath her chin while sitting at the nursing station with two (2) other staff members, which left her nose and mouth not covered.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185258	A. BUILDING ______ B. WING ______	09/01/2021

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	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 880	Continued From page 3 Interview with LPN #1, on 09/01/2021 at 2:40 PM, revealed she pulled her face mask down when she made a phone call and did not cover her nose and mouth when the call was completed. Interview revealed it the facility's policy for staff to wear a mask covering the nose and mouth while in the facility. She stated "I was educated within the last month on proper placement of Personal Protective Equipment (PPE) by the Staff Development Coordinator (SDC). Interview with the Infection Preventionist (IP), on 09/01/2021 at 3:01 PM, revealed face masks should be worn at all times while in resident care areas and the mask should cover the nose and mouth. She further stated all staff have been educated on proper placement of PPE and the importance of wearing the masks to prevent the spread of any possible COVID-19. Interview with the Director of Nursing (DON), on 09/01/2021 at 5:17 PM, revealed she expected staff to wear PPE properly, per the CDC guidelines and facility policy, to prevent the spread of infectious diseases, such as COVID-19. Interview with the Administrator, on 09/01/2021 at 5:17 PM, revealed he expected all staff to wear a face mask to cover the nose and mouth.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185258	A. BUILDING ______ B. WING ______	09/01/2021

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	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
E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted on 09/01/2021. There was no deficient practice identified at 42 CFR 483.73 related to E-0024 (b)(6).	E 000		

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.

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100514	A. BUILDING: ______ B. WING ______	R 10/12/2021

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	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) COMPLETE DATE
{N 000}	Initial Comments An Onsite Revisit conducted 10/12/2021 for the 07/15/2021 and 09/01/2021 surveys, determined the facility had achieved substantial compliance 10/08/2021, as alleged. A COVID-19 Focused Infection Control Survey (FICS) was conducted in conjunction with the onsite revisit. The facility was found to be in compliance pursuant to 42 CFR 483.80.	{N 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100514	A. BUILDING: ______ B. WING ______	09/01/2021

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	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) COMPLETE DATE
N 000	Initial Comments An Onsite Revisit and a COVID-19 Focused Infection Control Survey were conducted on 09/01/2021. The facility remained out of compliance pursuant to 42 CFR 483.80.	N 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden 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 Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number	Provider/Supplier Name
185258	LAKE WAY NURSING AND REHABILITATION CENTER

Type of Survey (select all that apply)

M	U	D		

- A Complaint Investigation
- B Dumping Investigation
- C Federal Monitoring
- D Follow-up Visit
- M Other
- E Initial Certification
- F Inspection of Care
- G Validation
- H Life Safety Code
- U COVID-19
- I Recertification
- J Sanctions/Hearing
- K State License
- L CHOW

Extent of Survey (select all that apply)

E				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey
E Abbreviated Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1. 44370	10/12/2021	10/12/2021	1.00	0.00	1.75	0.00	2.00	1.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.50

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 1.50

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden 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 Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number	Provider/Supplier Name
185258	LAKE WAY NURSING AND REHABILITATION CENTER

Type of Survey (select all that apply): M U

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
M Other
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
U COVID-19
I Recertification
J Sanctions/Hearing
K State License
L CHOW

Extent of Survey (select all that apply): E

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey
E Abbreviated Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1. 33035	09/01/2021	09/01/2021	0.50	0.00	4.00	0.00	2.50	1.50
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.25
Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 1.00
Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL

Andy Beshear
Governor

Division of Health Care
Western Branch
P.O. Box 2200 / 2400 Russellville Road
Hopkinsville, Kentucky 42241
Phone: (270) 889-6052
Fax: (270) 889-6089
https://chfs.ky.gov/agencies/os/oig

Eric C. Friedlander
Secretary

Adam Mather
Inspector General

October 22, 2021

via EMAIL: Paul Thomas Shepard (lkw74-admin@lakewaycare.com)

Mr. Paul Thomas Shepard, Administrator
Lake Way Nursing & Rehabilitation
2607 Main Street
Benton, KY 42025

Dear Mr. Shepard:

Thank you for submitting your proposed plan of correction regarding the deficiencies noted during the Focused Infection Control Survey completed on September 1, 2021.

Upon reviewing this plan, we found it to be acceptable. Based on implementation of your plan of correction, and the revisit completed on October 12, 2021, it was determined that the deficiencies had been corrected and your facility was in substantial compliance effective October 8, 2021.

We appreciate the cooperation extended to the representatives of our office. If you should have questions regarding this information, please contact our office.

Sincerely,

Darlene Fryar, RN, BS

Darlene Fryar, RN, BS
Human Services Program Branch Manager

DFF/TDM:lef

CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL

Andy Beshear
Governor

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Eric C. Friedlander
Secretary

Adam Mather
Inspector General

September 14, 2021

Paul Thomas Shepard (lkw74-admin@lakewaycare.com)

Mr. Paul Thomas Shepard, Administrator
Lake Way Nursing & Rehabilitation
2607 Main Street
Benton, KY 42025

Dear Mr. Shepard:

On September 1, 2021, a Focused Infection Control survey was completed at your facility by the Division of Health Care to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This visit found that your facility was not in substantial compliance with the participation requirements. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached CMS-2567, whereby corrections are required **(D)**.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Plan of Correction

You must submit an acceptable Plan of Correction (PoC) for all deficiencies that were cited during the September 1, 2021 survey, ten days after receipt of the Form CMS-2567. Please note an acceptable PoC will serve as your allegation of compliance. The failure to submit an acceptable PoC can lead to termination of your Medicare and Medicaid participation.

To be acceptable, your PoC must include the following:

- Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to ensure that solutions are sustained; and

- **Include dates when corrective action will be completed. In the right column with the heading 'completion date', include only one date for each corresponding deficiency with the heading 'ID Prefix Tag' listed in the left column.**

You are required to record your plan of correction in the appropriate column on the enclosed form(s) CMS-2567. **Sign, date, and indicate your title in the blocks provided at the bottom of page one.**

Informal Dispute Resolution

In accordance with 42 CFR 488.331 and 906 KAR 1:120, a provider shall have one informal opportunity to dispute a cited deficiency, or scope and severity assessment that constitutes Substandard Quality of Care or Immediate Jeopardy. You are required to send your request in writing to:

Chrystal Daugherty
IDR Coordinator
Office of Inspector General
Division of Health Care
116 Commerce Avenue
London, Kentucky 40744

Your request shall specify the format for the informal dispute resolution, specify the deficiency in dispute, explain the dispute, and provide a detailed basis for the dispute. Documentation in support of the dispute shall be attached to the request. The request and attachments shall be delivered **on or before the tenth calendar day after receipt of the Statement of Deficiencies.** A request for informal dispute resolution shall not delay an enforcement action.

Recommended Remedies

As a result of our finding that your facility was not in compliance with participation requirements, we are recommending to the Centers for Medicare and Medicaid Services (CMS) Regional Office the following:

- Mandatory termination if substantial compliance is not achieved **within six (6) months** from the last day of the survey identifying noncompliance, **Janurary, 15, 2022**.

- A civil money penalty of an amount and duration to be determined by CMS.

A change in the seriousness of the noncompliance at the time of a revisit may result in a change in the remedy(ies). If this occurs, you will be notified.

Discretionary Remedies

- Denial of payment for new admissions effective **September 22, 2021**

- Directed Plan of Correction (DPOC) for Tag F880:

In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction is imposed on the facility. In accordance with 42 CFR § 488.402(f), this remedy is effective **September 29, 2021.** The DPOC may be completed before or after that date. The effective date is not a deadline for completion of the DPOC. However, the State Agency will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice.

Requirements of the Directed Plan of Correction (DPOC):

- Training shall include:

  https://youtu.be/YYTATw9yav4

- Training will be targeted toward appropriate staff.

- Include documentation of the training completed with a timeline for completion.

- Training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion; and,

- Conduct a Root Cause Analysis (RCA), which will be done with the assistance from the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee, and the Governing Body. The RCA should be incorporated into the intervention plan. Information regarding RCAs can be found at **https://www.cms.gov/Medicare/Provider-Enrollment-and-and-Certification/QAPI/downloads/GuidanceforRCA.pdf**.

Please send all documentation to the State Agency at the following:

Terri Gipson, Regional Program Manager
Western State Hospital
P.O. Box 2200
2400 Russellville Road
Hopkinsville, KY 42241
Phone: 270-889-6052
Fax: 270-889-6089

Quality Improvement Organization (QIO) Resources

As your facility develops its PoC and DPoC, please keep in mind that the Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID19 and infection control strategies can be found at QIO Program Website, **https://qioprogram.org/covid-19**. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. Nursing homes that need assistance in developing a root cause analysis may desire to contact the QIO. QIOs per state can be found at Locate Your QIO, **https://qioprogram.org/locate-your-qio**.

Appeal Rights

If you disagree with enforcement remedies imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

Alternatively, you may file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at **https://dab/.efile.hhs.gov**.

Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Region4_DAB_HearingRequest@cms.hhs.gov

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense.

If you should have questions regarding this information, please contact our office.

Sincerely,

Darlene Fryar, RN, BS
Human Services Program Branch Manager

DFF/BCW:lef

cc: CMS Regional Office

Enclosure

How to Use the Departmental Appeals Board's Electronic Filing System (DAB E-File)

https://dab/.efile.hhs.gov

To file a new appeal using DAB E-File, you first must register a new account by: (1) clicking **Register** on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking **Register Account** at the bottom of the form. If you have more than one representative handling your appeal, each representative must register separately to use DAB E-File on your behalf.

How to log-in to DAB E-File. To access DAB E-File, the e-mail address and password provided during the registration process must be entered on the **Login** screen at https://dab.efile.hhs.gov/user_sessions/new. A registered user's access to DAB E-File is restricted to the appeals for which s/he is a party or authorized representative.

How to file an appeal (request for hearing) in DAB E-File. After you have registered and logged-in to DAB E-File, you may file an appeal by: (A) clicking the **File New Appeal** link on the **Manage Existing Appeals** page, then at the next page clicking the **Civil Remedies Division** button; then (B) entering and uploading the requested information and documents on the form labeled "File New Appeal – Civil Remedies Division."

Basic requirements for using DAB E-File. At a minimum, the DAB's Civil Remedies Division (CRD) requires a party filing an appeal to submit the following: (1) a signed hearing request; and (2) a copy of the underlying notice letter from CMS which sets forth CMS's adverse action and the party's appeal rights. All documents must be submitted in Portable Document Format (PDF). Any document, including a hearing request, will be deemed to have been filed on the date it is submitted via DAB E-File (through 11:59 p.m. EST on the date of submission). A party filing a hearing request via DAB E-File will be deemed to have consented to receiving and accepting electronic service of appeal-related documents which CMS subsequently submits via DAB E-File and/or which the CRD subsequently submits via DAB E-File on behalf of an Administrative Law Judge. CMS also will be deemed to have consented to electronic service.

Detailed information regarding DAB E-File. More detailed instructions for using DAB E-File in cases before the DAB's Civil Remedies Division can be found by clicking the button marked **E-Filing Instructions** after logging-in to DAB E-File.

For general questions regarding the DAB E-File System, you may call the Civil Remedies Division main telephone line at 202-565-9462. If you experience any technical issues with the DAB E-file System, please contact E-File System support. This support system may be reached at **SDABImmediateOffice@hhs.gov**.

CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL

Andy Beshear
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P.O. Box 2200 / 2400 Russellville Road
Hopkinsville, Kentucky 42241
Phone: (270) 889-6052
Fax: (270) 889-6089
http://chfs.ky.gov/os/oig

Eric C. Friedlander
Secretary

Adam Mather
Inspector General

September 14, 2021

Paul Thomas Shepard (lkw74-admin@lakewaycare.com)

Mr. Paul Thomas Shepard, Administrator
Lake Way Nursing & Rehabilitation
2607 Main Street
Benton, KY 42025

Dear Mr. Shepard:

Amendments were made to 902 KAR 20:300, Operation and Services; Nursing Facilities, effective December 12, 2018. Nursing facilities licensed under this regulation shall now comply with 42 CFR 483.10-483.95 as a condition of licensure and relicensure.

The Division of Health Care completed a Focused Infection Control Survey at your facility on September 1, 2021. This survey was conducted to determine compliance with these requirements. The survey found that your facility failed to meet minimum requirements for operation of a nursing facility.

The deficiencies cited for a violation of 42 CFR 483.80 are listed on the enclosed Form CMS-2567. An acceptable plan of correction submitted on the Form CMS-2567 will be considered an acceptable plan of correction for state licensure.

KRS 216.547 requires that all long-term care facilities shall retain, for public inspection in the office of the administrator and in the lobby of the facility, a complete copy of every inspection report of the facility received from the cabinet during the past three (3) years, including the most recent inspection report.

If you should have questions regarding this information, please contact our office.

Sincerely,

Darlene Fryar, RN, BS

Darlene Fryar, RN, BS
Human Services Program Branch Manager

DFF/TDM:lef

Enclosure