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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DA	(X3) DATE SURVEY COMPLETED	
185479			B. WING				11	11/17/2020	
NAME OF PROVIDER OR SUPPLIER THE HOME PLACE AT MIDWAY			187	101 SEXTO		STATE, ZIP CODE		71172020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (E	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
E 000	Initial Comments		E 0	000					
F 000	Survey was initiate concluded on 11/17 to be in compliance to E-0024 (b)(6).	sed Emergency Preparedness d on 11/17/2020 and 7/2020. The facility was found e with 42 CFR 483.73 related							
F 000	INITIAL COMMEN	TS	F0	00					
	was initiated on 11/ 11/17/2020. The fa compliance with 42 regulations and has Medicare & Medica Centers for Disease	sed Infection Control Survey 17/2020 and concluded on cility was found to be in CFR 483.80 infection control is implemented the Centers for id Services (CMS) and e Control and Prevention ed practices to prepare for ensus 28.	243				42		
				28				*3	
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							700		
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						2			
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		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 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING 101207 11/17/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **101 SEXTON WAY** THE HOME PLACE AT MIDWAY **MIDWAY, KY 40347** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated 11/17/2020 and concluded on 11/17/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. Total census 28.

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

TITLE

(X6) DATE