| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185479 | A. Building<br>B. Wing | 04/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Home Place at Midway | 101 Sexton Way<br>Midway, KY 40347 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure health information was maintained in a private and confidential manner for 1 of 12 sampled residents, Resident (R) 16. On 04/08/2025, R16's Medication Administration Record (MAR) was observed unattended and exposed to public view.<br><br>The findings include:<br><br>Review of the facility's policy titled, HIPAA [Health Insurance Portability and Accountability Act] Privacy Addendum, dated 03/05/2018, revealed the facility shall not disclose any protected health information.<br><br>Review of R16's Face Sheet revealed the facility admitted R16 on 03/18/2025 with diagnoses to include heart failure, stroke, and bipolar disorder.<br><br>Observation, on 04/08/2025 at 12:01 PM, revealed an unattended medication cart on the 300 Unit between the kitchen and porch. Further observation revealed R16's Medication Administration Record (MAR) was visible on the computer screen and in plain view. Registered Nurse (RN) 1, who was in charge of the medication cart, was not in the hall.<br><br>During interview with RN1 on 04/08/2025 at 12:04 PM, she stated she should not have left the resident's MAR pulled up on the computer screen because health information should be kept confidential.<br><br>During interview with the Director of Nursing (DON) on 04/10/2025 at 4:13 PM, she stated staff should always keep their computers closed when they were not with the computer.<br><br>During interview with the Administrator on 04/10/2025 at 4:34 PM, she stated she addressed each issue regarding resident privacy when they were brought to her attention. She stated she first established a time frame using a matrix. She stated the time frame for each incident varied according to the severity of the issue. She stated she then involved the Staff Development person to educate staff and followed-up to assure the issues were resolved. |

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 |
|---|---|---|

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy, the facility failed to ensure a written notice of transfer/discharge, which included the reason for the resident's transfer, was sent to a representative of the Office of the State Long-Term Care Ombudsman for 1 of 12 sampled residents, Resident (R) 28.<br><br>The findings include:<br><br>Review of the facility's policy titled, Discharge, last revised 09/29/2022, revealed for all discharges and transfers, including to an acute care facility, the Office of the State Long-Term Care Ombudsman was to be notified.<br><br>Review of R28's Face Sheet in the electronic medical record (EMR) revealed the facility admitted the resident on 01/14/2025 with diagnoses to include dementia, stroke, and chronic kidney disease. Further review of the EMR revealed the facility transferred R28 to the hospital on [DATE], but there was no documented evidence the Ombudsman had been notified in writing.<br><br>During interview with the Social Services Director (SSD) on 04/10/2025 at 1:47 PM, she stated she did keep a list of notifications to the Ombudsman of discharges from the facility. She stated they had a conversation about the discharges every time the Ombudsman was at the facility.<br><br>During telephone interview with the Ombudsman on 04/10/2025 at 2:02 PM, she stated she was not notified of residents who were discharged . She stated, when she came to the facility every month or two, she asked for a list of current residents and those that had been discharged .<br><br>During interview with the Director of Nursing on 04/10/2025 at 4:13 PM, she stated it was the responsibility of the SSD to notify the Ombudsman of all transfers/discharges.<br><br>During interview with the Administrator on 04/10/2025 at 4:34 PM, she stated her role was to assure the facility's policies were followed and to review the polices and address any issues. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and facility policy review, the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety. This deficient practice had the potential to affect all 22 current residents.<br><br>The findings include:<br><br>Review of the facility's Food Storage policy, revised 07/11/2024, revealed, Raw meat is to be stored in drip proof containers. Any expired or outdated food products should be discarded.<br><br>Observation in the kitchen on 04/08/2025 at 9:07 AM, revealed the front refrigerator had a container of cottage cheese that expired on 03/31/2025. Continued observation at 9:09 AM revealed a package of hamburger lying on the middle shelf, and it was not in a container. There were two uncovered melons on the shelf below.<br><br>During telephone interview with the Dietitian on 04/10/2025 at 2:02 PM, she stated all meat should be stored in a container on the bottom shelf. She further stated if the meat juice dropped on the melons, it could put the residents at risk for illness. She stated she would expect staff to store the meat in a container on the bottom shelf. She also stated staff should dispose of expired food because a resident could potentially become ill if they ate expired food.<br><br>During interview with the Director of Nursing (DON) on 04/10/2025 at 4:13 PM, she stated staff was to check the refrigerators for any expired foods and to store foods correctly. She stated eating expired food could cause a resident to become ill. She further stated staff should store meat so it could not drip onto other foods.<br><br>During interview with the Administrator on 04/10/2025 at 4:34 PM, she stated she was not aware of the issue with the food. She stated when she was informed of issues and errors were made, she educated staff to prevent recurrence. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, interview, record review, review of the Centers for Disease Control and Prevention (CDC)document, and review of the facility's policies, 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 and infection for 2 of 12 sampled residents, Resident (R) 2 and R16.<br><br>Observation on 04/08/2025 revealed staff did not perform correct hand hygiene when providing care to R2.<br><br>Observation on 04/08/2025 revealed staff did not correctly dispose of a gown worn during the care of R16, who was in Enhanced Barrier Precautions (EBP).<br><br>The findings include:<br><br>Review of the facility's Infection Prevention and Control and Surveillance Program policy, dated 11/01/2017, revealed staff was required to adhere to standard precautions and use personal protective equipment (PPE) according to infection control precautions.<br><br>Review of the facility's Hand Hygiene policy, revised 04/01/2024, revealed alcohol-based hand sanitizers should be used immediately upon removal of gloves. The policy further stated alcohol-based hand sanitizers should be used when moving from a soiled body site to a clean body site of the same resident.<br><br>Review of the CDC's document Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), updated July 12, 2022, revealed Enhanced Barrier Precautions (EBP) was an infection control intervention designed to reduce transmission of resistant organisms that employed targeted gown and glove use during high contact resident care activities. Per the document, signage needed to be posted, indicating the type of precautions and required PPE. It also stated to position a trash can inside the resident's room and near the exit for discarding PPE after removal, prior to exit of the room, or before providing care for another resident in the same room.<br><br>1. Observation on 04/08/2025 at 9:56 AM revealed R2 was lying in bed. Registered Nurse (RN) 1 was in the room getting medications. R2 asked to be cleaned, and the nurse called Certified Nurse Assistant (CNA) 1. CNA1 and RN1 cleaned R2's bowel movement. Per observation, CNA1 removed gloves and left the room to get linen. CNA1 opened the door then sanitized hands. Per observation of RN1, after cleaning R2's bowel movement, she cleaned the perineal area without changing gloves.<br><br>During interview with CNA1 on 04/08/2025 at 10:13 AM, CNA1 stated staff should sanitize each time gloves were removed because there could be a hole in the gloves, and it could spread infection.<br><br>During interview with RN1 on 04/08/2025 at 10:19 AM, she stated she should have changed her gloves when moving from R2's back to front. She further stated it could cause the resident to get an infection.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Observation on 04/08/2025 at 4:44 PM revealed a yellow gown (PPE) was on a chair outside R16's room, and there was no EBP sign on the door.<br><br>During interview with RN1 at the time of the observation, she stated she must have placed it there. She stated she should have put it in a container in the room. She stated she had been trained in infection control, she just forgot.<br><br>During interview with the Infection Preventionist (IP) on 04/10/2025 at 10:11 AM, she stated R16 was on EBP and she usually placed a sign on the resident's door indicating what type of precaution and what was required to care for residents, such as PPE and/or laundry restrictions. She stated the sign fell, and she had not replaced it. She stated she expected staff to either wash or sanitize their hands after changing gloves. She stated she would also expect staff to wash or sanitize their hands and change gloves when going from a dirty area to a clean area.<br><br>During interview with the Director of Nursing (DON) on 04/10/2025 at 4:13 PM, she stated the IP trained staff to follow precautions to prevent the spread of infection. She stated anytime the resident was in infection control precautions, staff should remove their PPE prior to leaving the room. She further stated staff was taught to wash or sanitize their hands after they removed their gloves.<br><br>During interview with the Administrator on 04/10/2025 at 4:34 PM, she stated her role in infection control was to be notified of any issues from staff, the IP, or the DON. She stated she expected staff to follow the facility's infection control policies, and her role was to assure the facility's policies were followed. She stated she reviewed the policies and made changes if needed. She stated, if there were problems, the Staff Development Coordinator educated staff. |