| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185479 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 05/04/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **The Home Place At Midway** | **101 Sexton Way , Midway, Kentucky, 40347** |

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| =0000 | INITIAL COMMENTS<br><br>Based on the off-site Revisit and implementation of the acceptable Plan of Correction (PoC), the facility was deemed to be in compliance on 03/24/2026, as alleged. | F0000 | | 05/05/2026 |

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 reverse for further 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.

| ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185479 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/26/2026 |
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| =0000 | INITIAL COMMENTS<br><br>A Recertification and Abbreviated Survey was concluded on 02/26/2026. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B.<br><br>No deficiencies were issued related to 715361, 2711224, or 2744143.<br><br>Survey Dates: 02/24/2026 to 02/26/2026<br><br>Survey Census: 26<br><br>Sample Size: 12<br><br>Supplemental Residents: 14 | F0000 | | 03/13/2026 |
| =0812<br>SS = F | Food Procurement,Store/Prepare/Serve-Sanitary<br><br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br><br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br><br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br><br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br><br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. | F0812 | On 2/26/26, the ice machine was removed and disposed of immediately by the Maintenance Director. All other ice machines were inspected for cleanliness and potential mold growth. No residents were identified as being affected by this practice.<br><br>All residents could be affected by this practice. The Infection Preventionist reviewed nursing notes over the past 30 days and did not find any resident with signs and symptoms of foodborne illness.<br><br>On 3/19/26, a new ice machine was received and installed . On 3/19/2026, inspection of ice machine was added to Ezers' weekly checklist to ensure no mold growth and attentiveness to cleanliness of the machine. Inspection of ice machines was added to the Dietary Managers audit form of kitchens. Beginning on 3/2/2026 and completed on 3/6/26, the Staff Development Coordinator educated all staff the proper way to wear hairnets. Any staff not working, on LOA or vacation will be trained prior to next working shift. Magnetic mirrors were placed on the fridge in pantry areas to allow staff to check for proper placement of their hairnet.<br><br>Beginning 3-16-2026 Hair net usage and Inspection of ice machines will be completed by the Dietary | 03/20/2026 |

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 reverse for further 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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| =0812<br>SS = F | Continued from page 1<br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, and review of the facility's documents, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. Observations made on 02/24/2026, 02/25/2026, and 02/26/2026 revealed mold contamination in the ice machine. Observations on 02/25/2026 revealed Ezer (an aide) 3's and Ezer 4's hair nets did not cover the front section of their hair.<br><br>This deficient practice had the potential to affect all 26 current residents.<br><br>The findings include:<br><br>Review of the facility's document "Kitchen Cleaning Schedule," not dated, revealed the ice machine was not included on the cleaning list or assigned a cleaning frequency.<br><br>Review of the 'Maintenance Logbook" revealed documented monthly cleaning entries from August 2025 through October 2025 and January 2026. However, there were no documented cleaning entries for November 2025, December 2025, or February 2026.<br><br>1. Observation on 02/24/2026 at 9:50 AM revealed the presence of mold inside the kitchen ice machine. Follow-up observations on 02/25/2026 at 10:03 AM and on 02/26/2026 at approximately 12:00 PM confirmed that mold was still present in the ice machine.<br><br>In an interview on 02/26/2026 at 10:14 AM, Ezer 7 stated the ice machine was cleaned per the sheet from the dietitian, and the vents were cleaned daily. Ezer 7 stated the ice machine was cleaned on the inside last week "because the ice was all gone."<br><br>In an interview on 02/26/2026 at 11:25 AM, the Support Service Manager (SSM) stated maintenance did a cleaning on the ice machine quarterly. The SSM stated Ezers were responsible for cleaning based on the "Kitchen Cleaning Schedule."<br><br>In an interview on 02/26/2026 at 3:48 PM, the Director of Nursing/Infection Preventionist (DON/IP) stated cleaning of the ice machine "is not in my | F0812 | Continued from page 1<br>Manager 5x per week for 4 weeks and weekly for 3 months to ensure no mold growth and cleanliness of the machine. Results of these audits will be presented by the Dietary Manager to QAPI, with the first meeting held on 3-19-2026, for 4 months with any areas for improvement identified and addressed through QAPI Action plans. The QAPI committee consists of: Executive Director, Director of Nursing, Staff Development Coordinator/Infection Preventionist, Social Service Director, Dietary Manager, Director of Rehab, MDS Coordinator, Consultant Pharmacist and Medical Director. | 03/20/2026 |

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| =0812 SS = F | Continued from page 2<br>realm, but I would hope it is cleaned weekly." The DON/IP stated mold in the ice machine was not acceptable and emphasized the importance of keeping it clean to protect residents' health.<br><br>In an interview on 02/26/2026 at 4:23 PM, the Administrator stated the ice machine was cleaned quarterly by Maintenance with a special solution. The Administrator stated mold in the ice machine was unacceptable. The Administrator stated it was important to keep the ice machine clean to prevent resident illness.<br><br>2. a. Observation on 02/25/2026 at 11:12 AM revealed Ezer 4 wore her hair net back from her forehead, leaving approximately three inches of hair exposed. Further observation revealed Ezer 4 walked around in the kitchen making tea and stirring a pot of food on the stove and did not adjust her hair net to cover her hair.<br><br>In an immediate interview, Ezer 4 stated her hair was long and heavy, and hair nets sometimes pulled back from her forehead. Immediately following the interview, Ezer 4 pulled her hair back and secured it before replacing the hair net, which now covered all her hair.<br><br>b. Observation on 02/25/2026 at 11:18 AM revealed Ezer 3's hair net did not cover the front section of her hair.<br><br>In an interview on 02/26/2026 at 4:23 PM, the Administrator stated she did not believe the facility had a policy specific to wearing hair nets.<br><br>In an interview on 02/26/2026 at 1:45 PM, the Dietary Manager stated staff should wear hair nets at all times in the kitchen. She further stated staff should ensure the hair nets covered all their hair to prevent hair from ending up in the resident's food.<br><br>In continued interview on 02/26/2026 at 3:48 PM, the Director of Nursing (DON) stated staff should always wear hair nets that covered all their hair while in the kitchen.<br><br>In an interview on 02/26/2026 at 4:23 PM, the Administrator stated staff in the kitchen should wear their hair nets covering their hair fully. | F0812 | | 03/20/2026 |
| =0880 SS = F | Infection Prevention & Control<br><br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control | F0880 | On 2/26/26, the Director of Nursing removed linens found on the floor and placed them in soiled laundry to be laundered. On 2/26/26, cloth aprons were immediately removed and replaced with plastic aprons to ensure no cross-contamination of soiled | 03/20/2026 |

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| =0880 SS = F | Continued from page 3<br><br>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.<br><br>§483.80(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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 §483.71 and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or<br><br>infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br><br>(iv)When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br><br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(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 | F0880 | Continued from page 3<br>items. On 2/26/26, the Maintenance Director increased the hot water heater temperature to 140 degrees. No residents were found to be affected by the deficient practice.<br><br>All residents could be affected by this practice. The Infection Preventionist reviewed nursing notes over the past 30 days and did not find any resident with signs and symptoms of Legionella or illness resulting from soiled laundry<br><br>Beginning on 3/2/26, the Staff Development Coordinator educated all staff on proper PPE when doing laundry, proper storage of clean laundry, and procedure for removing any clean laundry that may be potential contaminated. Any staff not working, on LOA or vacation will be trained prior to next working shift. New Linen carts were ordered and installed on 3-16-2026 to ensure proper storage of clean linens. The carts are labeled for organization and are safely draped on all sides to protect clean linens. An extra supply of PPE to include face shields, gloves and plastic aprons/gowns are maintained in a drawer in the soiled laundry room. On 3/11/2026, plumbing vendor, Whitehead-Hancock, replaced 2 mixing valves and verified temperature was above 140 degree threshold.<br><br>Beginning 3-2-2026 Maintenance Director will audit water temperatures in resident rooms and common areas 5x week for 4 weeks and weekly for 3 months to ensure temperatures fall within appropriate thresholds for safety and infection control.<br><br>On 3-2-2026 Infection Preventionist will audit laundry rooms and clean laundry storage 5x week for 4 weeks and weekly for 3 months to ensure proper PPE is available and used and clean laundry is stored correctly.<br><br>Results of these audits will be presented by DON to QAPI, with the first meeting held on 3-19-2026, for 4 months with any areas for improvement identified and addressed through QAPI Action plans. The QAPI committee consists of: Executive Director, Director of Nursing, Staff Development Coordinator/Infection Preventionist, Social Service Director, Dietary Manager, Director of Rehab, MDS Coordinator, Consultant Pharmacist and Medical Director. | 03/20/2026 |

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| F0880 SS = F | Continued from page 4<br><br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br><br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br><br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, 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 and control the development and transmission of communicable diseases. The deficient practices had the potential to affect all residents with a census of 26.<br><br>Observation and interviews on 02/26/2026 revealed hot water was stored at temperatures below the level needed to prevent growth of Legionella.<br><br>Observation of the Hope and Faith House laundry rooms on 02/26/2026 revealed the aprons provided were made of cloth and would not protect staff clothing from splashes from contaminated linens.<br><br>Observation of the Hope House clean linen storage on 02/26/2026 revealed clean blankets piled up on the floor beside the linen cart.<br><br>The findings include:<br><br>Review of the facility's policy titled, "Water Management Plan," not dated, revealed the facility was to establish a Water Management Team including the Administrator, Director of Nursing, and Maintenance Director. Further review revealed the facility identified water heaters as a potential source of Legionella growth. Continued review revealed the | F0880 | | 03/20/2026 |

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| =0880 SS = F | Continued from page 5<br>facility was to monitor water temperatures daily in each building. However, the policy did not provide a temperature range required for water heaters and circulating hot water.<br><br>Review of the Centers for Disease Control and Prevention (CDC) document "Monitoring Building Water," dated 03/15/2024, revealed healthcare facilities should store hot water at above 140 degrees Fahrenheit (F) to prevent Legionella growth.<br><br>In an interview on 02/26/2026 at 4:57 PM, the Maintenance Director stated he kept the water heaters set at 120 degrees F. He stated that temperature was what he was told by a contractor to set it at for Legionella management. In an additional interview at 6:05 PM, the Maintenance Director stated he did further research and found the recommended temperature for Legionella prevention was 130 degrees F, so he adjusted the water temperatures for each water heater accordingly.<br><br>1. Observation on 02/26/2026 at 6:05 PM revealed the temperature gauge for the water heater for the Hope House read 121 degrees F.<br><br>In interview on 02/26/2026 at 3:48 PM, the Infection Preventionist/Director of Nursing (IP/DON) stated she had not participated in the development of the water management plan. She further stated the facility did not have empty rooms or areas where water would be stagnant, so she believed the risk of Legionella growth was low.<br><br>In an interview on 02/26/2026 at 4:23 PM, the Administrator stated the facility relied on a contacting company to assess their water management program, and they followed their recommendations for Legionella prevention, which included testing annually. She further stated the contracting company did not provide them with recommendations on water temperatures.<br><br>Review of the facility's policy titled, "Infection Prevention and Control," dated 10/2025, revealed the facility was to follow national standards and guidelines to prevent and control the spread of infection and communicable diseases. Further review revealed the facility was to handle, store, process, and transport linens in a manner to prevent the spread of infection.<br><br>2.a. Observation on 02/26/2026 at 11:32 AM in the Hope House laundry room revealed the apron available for staff to use while cleaning heavily soiled linens made of cloth instead of an | F0880 | | 03/20/2026 |

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| =0880 SS = F | Continued from page 6<br>impermeable material.<br><br>Observation on 02/26/2026 at 11:46 AM in the Faith House laundry room revealed the apron available for staff to use while cleaning heavily soiled linens made of cloth instead of an impermeable material.<br><br>In an interview on 02/26/2026 at 3:48 PM, the IP/DON stated the aprons in the laundry rooms were for staff to wear while they rinsed heavily soiled linens to prevent splashing of potentially infectious material onto staff clothing. She stated the cloth aprons in the laundry rooms were permeable and would not protect staff members' clothing.<br><br>In an interview on 02/26/2026 at 4:23 PM, the Administrator stated it was important for the staff to have the appropriate personal protective equipment (PPE) to wear while handling soiled linens. She further stated the cloth aprons were not adequate because cloth would allow potentially contaminated material to soak through to staff members' clothing.<br><br>b. Observation on 02/26/2026 at 11:35 AM revealed the clean linen cart outside the laundry room in Hope House was overflowing. Further observation revealed a pile of clean blankets stacked beside the linen cart on the floor.<br><br>In an interview on 02/26/2026 at 3:48 PM, the IP/DON stated linens should be stored off the floor. She further stated if the cart was overflowing, the surplus linen should be stored elsewhere to keep it sanitary.<br><br>In an interview on 02/26/2026 at 4:23 PM, the Administrator stated clean linens should be stored on the linen cart or in clean linen baskets off the floor to keep them clean. | F0880 | | 03/20/2026 |
| =0565 SS = E | Resident/Family Group and Response<br><br>CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)<br><br>§483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility.<br><br>(i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.<br><br>(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. | F0565 | On 2/27/26, Resident Rights posters were moved into conspicuous location of each house for all residents and families to easily view. On 2/27/26, the Social Services Director (SSD) met with Residents and informed them of their right to organize and participate in resident groups in the facility and that Resident Council would be held on 3/12/2026.<br><br>All residents have the potential to be affected; however there is corrective plan of action in place.<br><br>On 3-12-26 SSD held resident council with 4 residents who wished to participate in a group | 03/20/2026 |

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| F0565 SS = E | Continued from page 7<br><br>(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.<br><br>(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.<br><br>(A) The facility must be able to demonstrate their response and rationale for such response.<br><br>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.<br><br>§483.10(f)(6) The resident has a right to participate in family groups.<br><br>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, and review of the facility's documents and policy, the facility failed to provide ongoing communication with residents about their rights to include not supporting and encouraging residents to organize and participate consistently in groups at the facility for 3 of 3 resident attendees present at the Resident Council meeting, Resident (R) R4, R5, and R25.<br><br>The findings include:<br><br>Review of the facility's policy titled, "Grievance Policy," dated 07/01/2015, explained the procedures residents may follow in filing a complaint; however, there was no mention of residents being permitted to discuss concerns or complaints in Resident Council.<br><br>Observation of the Resident Council meeting on 02/25/2026 at 10:30 AM revealed three residents were present, R4, R5, and R25. During the meeting, two of the residents expressed the desire to hold formal Resident Council meetings on a consistent basis. Furthermore, when asked about resident rights, all three participants stated they did not know | F0565 | Continued from page 7<br>setting, 3 other residents chose not to participate with the group but met individually with SSD. SSD will continue to hold monthly resident council meetings in group settings in each skilled housed house, giving all residents the ability to participate and exercise their rights. Minutes from these Resident Council meetings will be presented to the Executive Director for review and any issues needing follow-up. Resident Rights will continue to be discussed upon admission, during care plan meeting and any other time desired.<br><br>The Director of Social Services will report findings from resident council meetings monthly to the QAPI committee with the first report being at the QAPI 3-19-2026 with any areas for improvement identified and addressed through QAPI Action plans. The QAPI committee consists of: Executive Director, Director of Nursing, Staff Development Coordinator/Infection Preventionist, Social Service Director, Dietary Manager, Director of Rehab, MDS Coordinator, Consultant Pharmacist and Medical Director. | 03/20/2026 |

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| F0565 SS = E | Continued from page 8<br>what resident rights were and indicated that staff had not discussed their rights with them.<br><br>Review of R4's quarterly "Minimum Data Set [MDS]," with an Assessment Reference Date (ARD) of 02/20/2026, revealed the facility assessed the resident to have a "Brief Interview for Mental Status [BIMS]" score of 14 out of 15, which indicated the resident was cognitively intact.<br><br>Review of R5's quarterly "MDS," with an ARD of 01/22/2026, revealed the facility assessed the resident to have a "BIMS" score of 15 out of 15, which indicated the resident was cognitively intact.<br><br>Review of R25's quarterly "MDS," with an ARD of 11/20/2025, revealed the facility assessed the resident to have a "BIMS" score of 14 out of 15, which indicated the resident was cognitively intact.<br><br>Review of the Resident Council minutes obtained from the Administrator revealed on the dates of 11/25/2025,12/30/2025, and 01/29/2026, no formal Resident Council meetings were held. Further review revealed the notes for meetings on those dates were compiled from individual sessions with residents conducted by the Social Worker (SW).<br><br>During an interview with the SW on 02/25/2026 at 4:10 PM, she stated no formal meetings had been held with residents for "a few years." She further stated she had instead conducted individual meetings with the residents to discuss concerns or complaints, and that appeared to be their preference.<br><br>During a follow-up interview with the SW on 02/26/2026 at 1:15 PM, when asked if she documented conversations from her individual meetings with the residents, she stated she provided that information to the Administrator.<br><br>During an interview with the Director of Nursing (DON) on 02/26/2026 at 4:09 PM, she stated that no residents had expressed a desire to hold a Resident Council meeting. She stated that she thought the residents knew what a Resident Council was, but she was unsure if they had been provided with any information about resident rights. She further stated she did not know why the facility did not hold formal Resident Council meetings for the residents.<br><br>During an interview with the previous Administrator on 02/26/2026 at 4:22 PM, she stated after Covid, the residents agreed to do one-on-one sessions with the SW; however, the residents had been given the opportunity to go to another house on campus | F0565 | | 03/20/2026 |

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| =0565 SS = E | Continued from page 9<br>for formal group meetings. She further stated resident rights were often discussed during care planning meetings or other care settings.<br><br>During an interview with the Administrator on 02/25/2026 at 4:25 PM, she stated she had spoken previously with the Ombudsman and weighed options about holding a Resident Council meeting. She further stated due to the difficulty of getting a large group together, it was decided to keep it as it was, stating, "If it's working for you don't change it." | F0565 | | 03/20/2026 |
| =0755 SS = E | Pharmacy Srvcs/Procedures/Pharmacist/Records<br><br>CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, record review, and | F0755 | On 2-26-2026, discontinued controlled medications were immediately removed from medication rooms by the Director of Nursing and the Staff Development Coordinator. Controlled medications were secured in a separate location in preparation for destruction. ALL Discontinued controlled medications on hand were destroyed on 3/18/26. Medication rooms were inspected to ensure no other discontinued medications remained. No residents were found to be affected by the deficient practice.<br><br>All residents have the potential to be affected; however there is corrective plan of action in place.<br><br>From 2/26/26 thru 3/12/26-- the DON and Nurse Unit Manager did weekly rounds of medication cabinets and pulled discontinued medications on 3/03/06 and again on 3/12/26. All controlled medications on hand were destroyed on 3/18/26. Beginning on 3/2/2026, the Staff Development Coordinator educated all nurses on pulling all discontinued non-controlled medications in the resident's individual medication cabinet immediately and upon resident discharge. Any nurses not working, on LOA or vacation will be trained prior to next working shift.<br><br>Beginning 3-16-2026, Weekly rounds will be made by SDC and Nurse Unit Manager and any discontinued controlled medications will be removed from controlled medication cabinet and secured for destruction. Destruction of all discontinued controlled medications will occur monthly. Beginning 3-19-2026 audits to ensure all discontinued controlled medications are removed from the controlled medications cabinet in each house will conducted by DON weekly for 3 months and monthly for an additional 3 months. Beginning March 2026, the Pharmacist consultant will audit medication rooms monthly to ensure no discontinued | 03/24/2026 |

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| =0755 SS = E | Continued from page 10<br>facility policy review, the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation for 2 out of 2 medication rooms observed, the Faith House Medication Room and the Hope House Medication Room.<br><br>Observation on 02/25/2026 of the Faith House Medication Room revealed three controlled substances belonging to Residents (R) 32 and R33, who no longer resided in the facility.<br><br>Observation on 02/25/2026 of the Hope House Medication Room revealed four controlled medication containers for R34 and two controlled medication containers for R35. Neither resident currently lived in the facility.<br><br>The findings include:<br><br>Review of the facility's policy titled, "Medication Storage in the Facility," date revised 08/2014, revealed, "Medication storage conditions are monitored on a monthly basis by the consultant pharmacist or pharmacy designee and corrective action taken if problems identified." Further review of the policy revealed, "Controlled substances remaining in the facility after the order has been discontinued or the resident has been discharged are retained in the facility in a securely locked area with restricted access until destroyed."<br><br>Review of Resident (R) 32's "Face Sheet" revealed the facility discharged the resident on 01/24/2026.<br><br>Review of R33's "Face Sheet" revealed the facility moved the resident to an outpatient status on 01/20/2026 and no longer resided in the facility.<br><br>1. Observation on 02/25/2026 at 10:05 AM of the Faith House Medication Room revealed one controlled substance in the double locked medication cabinet belonging to R32, 25 tablets of alprazolam (an anti-anxiety agent) 0.25 milligram (mg). Further review revealed two controlled substances belonging to R33, 26 tablets of oxycodone (an opioid pain reliever) 5 mg and 32 tablets of alprazolam 0.25 mg. Additional observation on 02/26/2026 at 10:18 AM revealed those controlled substances remained in the cabinet.<br><br>In an interview with Licensed Practical Nurse (LPN) 1 on 02/25/2026 at 10:10 AM, she stated R32 and R33 | F0755 | Continued from page 10<br>medications are present. DON and Pharmacist consultant will report findings to QAPI committee with first meeting to be held on 3-19-26, with any areas for improvement identified and addressed through QAPI Action plans. The QAPI committee consists of: Executive Director, Director of Nursing, Staff Development Coordinator/Infection Preventionist, Social Service Director, Dietary Manager, Director of Rehab, MDS Coordinator, Consultant Pharmacist and Medical Director.<br><br>Weekly removal of narcotics from all Narcotic medication cabinets and monthly destruction of controlled medications will continue to be the process and the medication removal process policy was reviewed and revised on 3-20-2026 to reflect this practice. On 3-23-2026 DON educated all nurses on the revised policy. Any nurses not working, on LOA or vacation will be trained prior to next working shift. | 03/24/2026 |

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| F0755 SS = E | Continued from page 11<br>no longer lived at the facility, and she was unsure as to why the medications had not been collected and disposed of.<br><br>Review of R34's "Death Record Minimum Data Set [MDS]," dated 02/17/2026, revealed the facility admitted R34 on 01/07/2026, and the resident died in the facility on 02/11/2026.<br><br>Review of R35's "Discharge MDS," dated 02/06/2026, revealed the facility discharged the resident as a planned discharge on 01/30/2026.<br><br>2. Observation on 02/25/2026 at 11:04 AM of the Hope House Medication Room revealed the following controlled medications for R34 in the double locked medication cabinet: one bottle of liquid morphine (an opioid pain reliever), 38 tablets of tramadol (an opiate pain reliever) 50 mg, 57 tablets of lorazepam (an anti-anxiety agent) 1 mg, and 1 skid of lorazepam 5 mg. Further observation revealed the following controlled medications for R35: 40 tablets of gabapentin (a pain reliever) 300 mg and 42 tablets of oxycodone.<br><br>In an immediate interview, Registered Nurse (RN) 1 stated the medications in the top shelf of the medication cabinet, where the above listed medications were located, was where nurses put medications for residents who had been discharged, or the physician had adjusted the dose of the medication. She further stated there should not be so many controlled substances not in use stored in the medication cabinet because every nurse for Hope House would have access to the cabinet, and the medications would be at risk for diversion or causing a medication error. RN1 stated the Director of Nursing (DON) and Staff Development Coordinator (SDC) used to audit and remove medications no longer in use from the cabinet, but she had noticed those audits were no longer occurring as frequently as they used to, leading to medications piling up in the cabinet.<br><br>In an interview with RN3 on 02/26/2026 at 10:18 AM, she stated the Schedule Coordinator and the DON made rounds "sporadically." RN3 stated, "I do not feel they collect controlled medications from residents who are discharged or have medication changes as often as they should."<br><br>In an interview with the Scheduling Coordinator on 02/26/2026 at 11:12 AM, she stated she and the DON collected controlled medications from the double locked cabinets and transported them to the | F0755 | | 03/24/2026 |

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| =0755 SS = E | Continued from page 12<br>Administration building, where they were placed in a double locked cabinet until it was full. She stated once that cabinet was full, they disposed of the controlled medications by placing the medications in a solution to break them down and then placing that solution into cat litter. She stated this process had occurred twice since August 2025. She stated it was important to remove the medications in a timely manner to prevent medication errors.<br><br>In an interview on 02/26/2026 at 3:48 PM, the DON stated the facility's process for auditing the medication storage cabinets was for the SDC to go with the DON on a monthly basis to collect controlled medications no longer in use from each storage cabinet and destroy them. She stated it was important to follow this process to reduce the risk of drug diversion and medication errors. The DON stated the facility had been without an SDC for several months, so the medication audits had not been occurring as frequently as they needed to, leading to an accumulation of unused medications in the cabinet.<br><br>In an interview on 02/26/2026 at 4:23 PM, the Administrator stated her expectation for management of the controlled substance cabinets was for the DON and SDC to conduct frequent audits on the medication counts and remove and destroy medications no longer in use. | F0755 | | 03/24/2026 |
| =0628 SS = D | Discharge Process<br><br>CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)<br><br>§483.15(c)(2) Documentation.<br><br>When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.<br><br>(iii) Information provided to the receiving provider must include a minimum of the following:<br><br>(A) Contact information of the practitioner responsible for the care of the resident.<br><br>(B) Resident representative information including contact information<br><br>(C) Advance Directive information | F0628 | R28 was discharged on 1/12/2026. Effective 2/27/26, all residents who are transferred or discharged, will receive a bed hold policy and notice as well as a written notice of the discharge to include: reason for discharge, effective date of discharge, and resident's appeal rights including name and contact information of the entity that handles discharge appeals.<br><br>All residents have the potential to be affected; however there is corrective plan of action in place.<br><br>Nurses were in-serviced on 2/19/26 during monthly nurse meeting on Notice of Transfer and Bed Hold Policy and again during monthly nurse meeting for March (3/19/26). Education included where "Notice of Transfer/Bed Hold Policy" forms are kept and to send top sheet (white copy) with the patient when sending them out to the hospital and give yellow copy to family member if family is available. If no family is available, SSD will mail or email yellow copy on the next business day. Facility to keep pink copy. Any nurses not working, on LOA or vacation | 03/20/2026 |

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| =0628 SS = D | Continued from page 13<br>(D) All special instructions or precautions for ongoing care, as appropriate.<br><br>(E) Comprehensive care plan goals;<br><br>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.<br><br>§483.15(c)(3) Notice before transfer.<br><br>Before a facility transfers or discharges a resident, the facility must-<br><br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br><br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and<br><br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br><br>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.<br><br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br><br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br><br>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;<br><br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;<br><br>(D) An immediate transfer or discharge is required | F0628 | Continued from page 13<br>will be trained prior to next working shift.<br><br>Beginning on 2/27/26, The Social Services Director (SSD) will keep a spreadsheet of transfer and discharges and audit each one to ensure bed hold policy and transfer/discharge notice was provided to resident and responsible party at upon transfer or discharge. SSD will report findings of these audits monthly for 6 months to QAPI committee with first meeting being held on 3-19-26, with any areas for improvement identified and addressed through QAPI Action plans. The QAPI committee consists of: Executive Director, Director of Nursing, Staff Development Coordinator/Infection Preventionist, Social Service Director, Dietary Manager, Director of Rehab, MDS Coordinator, Consultant Pharmacist and Medical Director. | 03/20/2026 |

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| =0628 SS = D | Continued from page 14<br>by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or<br><br>(E) A resident has not resided in the facility for 30 days.<br><br>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:<br><br>(i) The reason for transfer or discharge;<br><br>(ii) The effective date of transfer or discharge;<br><br>(iii) The location to which the resident is transferred or discharged;<br><br>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;<br><br>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;<br><br>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and<br><br>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.<br><br>§483.15(c)(6) Changes to the notice.<br><br>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. | F0628 | | 03/20/2026 |

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| =0628 SS = D | Continued from page 15<br><br>§483.15(c)(8) Notice in advance of facility closure<br><br>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).<br><br>§483.15(d) Notice of bed-hold policy and return-<br><br>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-<br><br>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;<br><br>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;<br><br>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1 ) of this section, permitting a resident to return; and<br><br>(iv) The information specified in paragraph (e)(1) of this section.<br><br>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.<br><br>§483.21(c)(2) Discharge Summary<br><br>When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:<br><br>(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, | F0628 | | 03/20/2026 |

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| =0628 SS = D | Continued from page 16<br>radiology, and consultation results.<br><br>(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.<br><br>(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and record review, the facility failed to notify the resident and the resident's representative of the transfer and the reasons for the move in writing for 1 of 1 resident investigated for hospitalizations, Resident (R) 28.<br><br>R28 was transferred to the hospital on 01/12/2026; however, the facility failed to send a written notice of transfer to the resident's representative. Furthermore, the facility failed to provide evidence of sending the resident's representative a written copy of the bed hold notice for that hospitalization.<br><br>The findings include:<br><br>Review of R28's "Admission Record" revealed the facility admitted the resident on 01/09/2026 with diagnoses including hip fracture, Alzheimer's disease, and benign prostate hyperplasia (enlarged prostate).<br><br>Review of R28's "Nurse's Note," dated 01/12/2026, revealed the facility transferred the resident to the hospital for blood in his urine.<br><br>Review of R28's medical record revealed no evidence the resident's representative received a written notice describing the destination and reason for transfer, resident rights related to appeals, and contact information for state agencies. Further review revealed no evidence the facility sent the resident's representative a written bed hold notice for that hospitalization.<br><br>Review of the "Summary of Episode Note," dated 01/12/2026, provided by the facility in response to the State Survey Agency request for transfer paperwork given to R28's representative, revealed the packet contained required clinical information for the hospital related to R28's care needs but no evidence of a bed hold notice or notice of transfer. | F0628 | | 03/20/2026 |

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| =0628<br>SS = D | Continued from page 17<br>In an interview on 02/26/2026 at 3:44 PM, R28's Power-of-Attorney (POA) stated the facility did not send him any paperwork related to R28's transfer to the hospital and the resident's rights related to transfers.<br><br>In an interview on 02/26/2026 at 4:23 PM, the Administrator stated the facility process when a resident was transferred to the hospital was to call the family to consult them, but the facility did not send a written notice. She further stated she expected the written bed hold notice to go to the hospital with the resident upon transfer. | F0628 | | 03/20/2026 |