STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185279	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mills Nursing & Rehabilitation	500 Beck Lane Mayfield, KY 42066

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility document and policy review, the facility failed to store and prepare foods under proper sanitary conditions and failed to ensure food preparation equipment was clean. The deficiency had the potential to affect all residents who received food from the kitchen.The findings include: A facility policy titled, Food Storage: Cold, dated October 2019, revealed, It is the center policy to insure [sic] all Time/Temperature Control for Safety (TCS), frozen and refrigerated food items, will be appropriately stored in accordance with guidelines for the FDA [Food and Drug Administration] Food Code. The policy revealed, 5. The Dining Services Director/ Cook(s) insures [sic] that all food items are stored properly in covered containers, labeled and dated and arranged in a manner to prevent cross contamination. A facility policy titled, Food Storage- Dry Goods, dated October 2019, revealed, It is the center policy to insure [sic] all dry goods will be appropriately stored in accordance with guidelines of the FDA Food Code. The policy revealed, 5. The Dining Services Director or designee ensures that all packaged and canned food items shall be kept clean, dry, and properly sealed. A facility policy titled, Environment, dated October 2019, revealed, It is the center policy that all food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition The policy revealed, 3. The Dining Services Director will insure [sic] that all food contact surfaces are cleaned and sanitized after each use. The policy revealed, 5. The Dining Service Director will insure [sic] that all dining areas are cleaned and sanitized after each use, including table surfaces, chairs, and floors. Facility documents titled [NAME] (Daily Cleaning List) included the following tasks to be completed by the AM shift and the PM shift:- Steam Table (Cleaned out, wiped down and refilled for next shift.- Contact Surfaces (Tables, Sinks, shelves wiped down and cleared of all debri [sic].- Fryer (Fryer is to be filtered after ever [sic] use to ensure good oil quality.- Equipment (All used equipment has been properly cleaned and put away in proper place.The documents revealed that staff documented the tasks were completed each shift from 04/26/2026 through 05/17/2026, the day prior to the survey. An initial tour of the kitchen on 05/18/2026 at 9:10 AM, accompanied by Dietary Manager (DM) #1, revealed one dented can of refried beans on the shelf stored alongside all other canned products. A build-up of grease, dirt, dust, and food particles was observed on the inner walls and exterior surface of the fryer. There was dried food residue and splattered grease from the top of the fryer to the base. A roll-up door that was approximately five feet wide and went from the top of the steam table to near the ceiling, used to separate the dining room from the kitchen outside of mealtimes, was observed with a build-up of food, dust, and dirt. The steam table was observed with large amounts of sticky yellow substance, grease, dirt, and food particles on the front area. The shelf at the bottom of the steam table, where serving pans were being stored, and temperature regulating knobs were observed with a build-up of food particles, grease, and dirt. During an interview on 05/18/2026 at 9:15 AM, DM #1 confirmed the presence of the dented can of refried beans on the shelf with the other canned goods. He immediately removed the can and placed it on a separate shelf, stating that he checked all the shelves all the time; I must have missed that one. DM #1 stated that dented cans were usually placed on a separate shelf, and it was everyone's responsibility to check the storage room and (continued on next page)

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	remove dented cans and place them on the dented can shelf. An observation of the kitchen on 05/19/2025 at 11:15 AM revealed the roll-up door with food and dirt build-up. The steam table had a sticky discolored substance, dirt build-up, and food particles were on the bottom shelf and temperature control knobs. Oil observed in the deep fryer contained a thick layer of cooled grease on the surface. Food droppings remained at the base of the fryer, with burnt areas observed along the borders of the fryer's inner ring. The exterior of the fryer was observed with grease build-up on the temperature control knobs and the entire front area of the fryer and along the lateral side from top to bottom. An observation of the walk-in freezer on 05/19/2026 at 3:27 PM, accompanied by Regional Director of Operations (RDO) #3, revealed an opened box of raw hamburger patties with the patties having a variation of pink and brown colors, with a light tan color surrounding the edges. RDO #3 acknowledged the findings and immediately removed the box and instructed [NAME] #2 to discard the contents. RDO #3 stated that the patties were not properly stored and that the box should have been sealed. During an interview on 05/19/2026 at 3:38 PM, [NAME] #2 revealed that he assisted with stocking and restocking the storage rooms. He stated that he made sure that there was no spoiled or old food, and if he found any, he removed it. He stated that dented cans were to be placed on a separate shelf, and if he found any, he informed DM #1 so the company could be notified. He stated that it was either him or the other chef who probably left the box of hamburger patties opened due to rushing to get some while cooking. He stated, It is everybody's responsibility to check all the time and make sure things are right. During a follow-up interview on 05/19/2026 at 4:01 PM, RDO #3 stated that everyone should be making sure food containers were closed properly. An observation of the kitchen area on 05/20/2026 at 2:40 PM revealed the roll-up door was observed with food splatter and dirt build-up. The steam table had a sticky discolored substance, dirt build-up, and food particles on the bottom shelf and the temperature regulating knobs. The deep fryer was observed with oil containing droppings from foods fried and food particles clinging to the surrounding surface and the exterior of the equipment. During an interview on 05/20/2026 at 3:08 PM, Dietary Aide (DA) #4 stated that the dietary aides were responsible for cleaning the counters, sinks, and floors in the kitchen and the cooks were responsible for cleaning the fryers, ovens, and the steam table. She stated that there used to be a schedule but had not been lately. During an interview on 05/20/2026 at 3:42 PM, Cook/DA #10 stated that she was the cook on certain days and worked as the dietary aide on other days. She stated that there was a schedule book that listed the responsibilities of the kitchen staff that must be initialed after a task was completed. She stated that she worked in the facility on Saturday, 05/16/2026, and completed all the cleaning at the end of her shift and initialed the schedule book. Cook/DA #10 confirmed the build-up of food particles, grease, and dirt on the steam table and its bottom tray and the external areas, as well as the roll-up door. She also confirmed the dark areas and burned food particles in the oil and on the inside and outside of the deep fryer. Cook/DA #10 stated that the fryer should be filtered after every use by pressing a button and old oil dumped, and cleaning was to be completed weekly and that the fryer should be wiped clean after every use. During an interview on 05/20/2026 at 3:56 PM, RDO #3 stated that the staff had a cleaning schedule and were expected to complete their cleaning task. RDO #3 stated that if staff were at least wiping it daily and completing the weekly cleaning tasks, and cleaning at least every six months, then it would be easier to manage. She stated that the build-up was not from just one day of cleaning tasks not being done. During an interview on 05/21/2026 at 9:58 AM, the Director of Nursing (DON) revealed that he expected the kitchen to be maintained in a clean condition and the equipment to be clean. During an interview on 05/21/2026 at 10:27 AM, the Administrator revealed that it was his expectation that the kitchen be maintained in clean condition and that the facility policy be followed. He stated that food should be labeled and dated. He stated that staff had schedules for cleaning and maintaining, but things happened and things got left open. He stated that there should be a dented can policy that the staff should be following and that there was a separate rack where the dented cans were stored so they could be replaced or sent back to the supplier.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and facility document and policy review, the facility failed to report an allegation of abuse for 1 (Resident (R)33) of 1 sampled resident reviewed for abuse. Specifically, an allegation of abuse that Resident 33 made toward Resident 34 was investigated by the facility but not reported to the state agency.The findings include: A facility policy titled, Abuse Neglect and Exploitation Policy, dated 04/2026, indicated, Y. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all required agencies (e.g. [exempli gratia], for example, law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. 1. A Resident Face Sheet revealed the facility admitted R33 on 05/05/2023. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of multiple sclerosis, myasthenia gravis, chronic obstructive pulmonary disease, dementia, and major depressive disorder. An annual Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 03/17/2026, revealed R33 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. Resident 33's Care Plan, revealed a problem statement dated 01/11/2024, that indicated the resident had behavioral symptoms. Nursing interventions included avoiding over-stimulation, maintaining a calm environment, and providing comfort when the resident became disruptive. 2. A Resident Face Sheet revealed the facility admitted Resident 34 on 02/21/2022. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of Parkinson's disease, major depressive disorder, and dementia. A quarterly MDS, with ARD of 03/17/2026, revealed Resident 34 had a BIMS score of 5, which indicated the resident had severe cognitive impairment. Resident 34's Care Plan, revealed a problem statement dated 12/19/2025, that indicated the resident had behavioral symptoms. Nursing interventions included redirection, avoiding over-stimulation, maintaining a calm environment, and providing comfort when the resident wandered. During an interview on 05/18/2026 at 12:04 PM, R33 stated R34 hit them about a month prior. Resident 33 stated they were unable to provide further details. During an interview on 05/18/2026 at 12:17 PM, the Administrator stated he was familiar with the altercation between Resident 33 and Resident 34 and had already investigated it. A facility document titled, Summary of Investigation dated 02/16/2026 revealed that an alleged altercation between Resident 33 and Resident 34 occurred on 02/15/2026. The summary revealed the facility completed interviews with all staff that worked on 02/15/2026, all residents in the [NAME] Hall were interviewed, and skin assessments were completed on residents that had a BIMS score of less than 8. The summary included a typed interview with Resident 33 conducted by the Administrator and the DON that revealed the resident stated the bruise on their back were due to Resident 34 hitting them and that Resident 34 hit them in the face and kicked them in both legs. Further review revealed Resident 33 stated that Resident 34 was working with two short kids in their 40's and that they wanted to hurt them (Resident 33). The typed interview revealed Resident 33 continued to tell staff that Resident 34 beats them and wants to kill them. The summary included a typed interview with Resident 34 conducted by the Administrator that revealed the resident stated they would never hit anyone. During an interview on 05/19/2026 at 1:41 PM, the Administrator said there was no report made to the state agency for the alleged altercation between Resident 33 and Resident 34. The Administrator stated that the facility handled it internally because Resident 33 had a history of false claims. During an interview on 05/21/2026 at 8:25 AM, the Director of Nursing (DON) stated the facility had a two-hour window to report abuse allegations to the state. The DON stated that Resident 33's abuse allegation was nonsensical. The DON stated staff completed a skin assessment, but there was no bruising other (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	than from a previous fall that he was aware of. The DON stated the facility administration felt the event was not something to be reported and unsubstantiated it at the facility level. During an interview on 05/21/2026 at 8:51 AM, the Administrator stated if they could rule out an abuse allegation on the spot, they used common sense and handled it internally and did not report it. The Administrator stated that they still investigated the incident. The Administrator stated that for abuse allegations that he reported to the state, he tried to have it reported within the hour. During an interview on 05/21/2026 at 2:05 PM, the Administrator stated they had to use common sense with reporting. The Administrator stated if the resident said they were beaten and bruised in the face, but there were no bruises, he did not believe that required reporting to the state agency.