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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185479	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER The Home Place at Midway		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Sexton Way 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 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 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.This deficient practice had the potential to affect all 26 current residents.The findings include: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. 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. 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. 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. 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. 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 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. 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.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.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.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. 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.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.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.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.

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

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 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.Observation and interviews on 02/26/2026 revealed hot water was stored at temperatures below the level needed to prevent growth of Legionella.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.Observation of the Hope House clean linen storage on 02/26/2026 revealed clean blankets piled up on the floor beside the linen cart.The findings include: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 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.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.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.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. 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.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.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.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 impermeable material.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.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.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.b. Observation on 02/26/2026 at 11:35 AM revealed the clean linen cart outside the laundry room in Hope House was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	overflowing. Further observation revealed a pile of clean blankets stacked beside the linen cart on the floor.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.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.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 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. The findings include: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. 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 what resident rights were and indicated that staff had not discussed their rights with them.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. 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.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. 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).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.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.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.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 for formal group meetings. She further stated resident rights were often discussed during care planning meetings or other care settings.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.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and 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.Observation on [DATE] of the Faith House Medication Room revealed three controlled substances belonging to Residents (R) 32 and R33, who no longer resided in the facility.Observation on [DATE] 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. The findings include: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. Review of Resident (R) 32's Face Sheet revealed the facility discharged the resident on [DATE]. Review of R33's Face Sheet revealed the facility moved the resident to an outpatient status on [DATE] and no longer resided in the facility. 1. Observation on [DATE] 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 [DATE] at 10:18 AM revealed those controlled substances remained in the cabinet. In an interview with Licensed Practical Nurse (LPN) 1 on [DATE] at 10:10 AM, she stated R32 and R33 no longer lived at the facility, and she was unsure as to why the medications had not been collected and disposed of. Review of R34's Death Record Minimum Data Set [MDS], dated [DATE], revealed the facility admitted R34 on [DATE], and the resident died in the facility on [DATE].Review of R35's Discharge MDS, dated [DATE], revealed the facility discharged the resident as a planned discharge on [DATE]. 2. Observation on [DATE] 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.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.In an interview with RN3 on [DATE] 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. In an interview with the Scheduling Coordinator on [DATE] at 11:12 AM, she stated she and the DON collected controlled medications from the double locked cabinets and transported them to the Administration building, where they were placed in a double locked cabinet (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 [DATE]. She stated it was important to remove the medications in a timely manner to prevent medication errors. In an interview on [DATE] 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.In an interview on [DATE] 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.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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.R28 was transferred to the hospital on [DATE]; 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. The findings include: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).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.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.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.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.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.