STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N008009	A. BUILDING: _____ B. WING _____	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF EL DORADO	1650 E 12TH AVENUE EL DORADO, KS 67042

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S 000	INITIAL COMMENTS The following citations represent the findings of a Re-Licensure survey with complain investigation 185199 for the above named Assisted Living Facility conducted on 01/29/2024, 01/30/24, and 01/31/24.	S 000		
S3082 SS=E	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: K.A.R 26-41-201 (d) The facility reported a census of 37 Residents (R). The sample included three residents and two focused record reviews. Based on interview and record review the executive director failed to ensure designated staff completed "Functional Capacity Screen" accurately for R3 and R4 to reflect their functional ability and need for health care services. Findings included: - R3's Electronic Medical Record revealed she moved into the facility on 11/10/17 with diagnoses of dementia with behavioral disturbance and dysphagia (swallowing difficulty). On 01/29/24 at 04:30 PM Administrative Staff A reported the "Functional Capacity Screen" and "Negotiated Service Agreement" were one document (FCS/NSA) and the "Health Care	S3082		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S3082	Continued From page 1	S3082		

Service Plan" (HCSP) was a separate document. All documents were signed by the licensed nurse and resident/legal representative.

R3's FCS/NSA dated 11/28/23 revealed she needed physical assistance with transfers, meaning she could participate in the transfer process and needed help with guided maneuvering of limbs or weight. It also identified the resident used a mechanical lift for all transfers. The FCS/NSA did not have "inappropriate behaviors" marked to indicate she had behaviors.

R3's HCSP included a section for problem behaviors and noted the resident took Seroquel (an antipsychotic medication) to help control behaviors. It directed staff to remove R3 from situation where increased agitation is noted and her anxiety may increase when staff try to get her changed or a shower.

Observation on 01/30/24 at 10:36 AM Certified Medication Aide (CMA) L and Certified Nurse Aide (CNA) K went into R3's room to transfer her from the wheelchair to the bed to provide incontinent care. CMA L hooked the sling to the mechanical lift. They raised R3 up out of the wheelchair, moved her over to the bed, and then lowered her onto the bed.

On 01/31/24 at 07:52 AM CMA G reported R3 needed full assistance with cares and staff used the full lift to transfer her. CMA G reported the resident would hit staff at times when trying to provide care. CNA G further reported R3 would yell at staff or blow in their faces when she did not want to change.

On 01/31/24 at 08:16 AM Administrative Licensed

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S3082	Continued From page 2	S3082		

Nurse B confirmed staff used the full lift for transfers and she did have behaviors at times. She acknowledged the FCS/NSA was not coded correctly for transfers and behaviors.

The operator failed to ensure designated staff coded R3's FCS/NSA correctly to identify she was dependent on staff for transfers and had inappropriate behaviors.

- R4's Electronic Medical Record revealed he moved into the facility on 03/17/21 with diagnosis of peripheral vascular disease, right below the knee amputation, and left above the knee amputation.

On 01/29/24 at 04:30 PM Administrative Staff A reported the "Functional Capacity Screen" and "Negotiated Service Agreement" were one document (FCS/NSA) and the "Health Care Service Plan" (HCSP) was a separate document.

R4's most current FCS/NSA dated 09/13/23 revealed he needed physical assistance with transfers, meaning he could participate in the transfer process and needed help with guided maneuvering of limbs or weight. It also identified the staff used a mechanical lift for all transfers.

Observation on 01/31/24 at 08:40 AM revealed Certified Nurse Aide (CNA) K and Certified Medication Aide (CMA) L went into R4's room and positioned the mechanical lift in front of him. CMA L hooked the sling to the lift and told R4 to fold his hands on his lap. Staff raised him up out of his electric wheelchair and then positioned him over his bed and lowered him onto the center of his bed.

On 01/31/24 at 11:20 AM Administrative Licensed

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S3082	Continued From page 3 Nurse B acknowledged transfers should have been coded a "3" instead of a 2. The operator failed to ensure designated staff completed R4's FCS accurately related to transfers.	S3082		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (d)(2) The facility reported a census of 37 residents (R). The sample included three residents and two focused record reviews. Based on observation, interview, and record review the operator failed to ensure designated staff reviewed and revised the "Negotiated Service Agreement" for one (R4) of three sampled residents when the resident experienced a significant change in status related	S3092		

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S3092	Continued From page 4	S3092		

to wounds.

Findings included:

- R4's electronic medical record revealed he moved into the facility on 03/17/21 with diagnosis of peripheral vascular disease, right below the knee amputation and left above the knee amputation.

On 01/29/24 at 04:30 PM Administrative Staff A reported the "Functional Capacity Screen" and "Negotiated Service Agreement" were one document (FCS/NSA) and the "Health Care Service Plan" (HCSP) was a separate document.

R4's most current FCS/NSA dated 09/13/23 revealed the resident needed physical assistance with all activities of daily living except for eating. He used a hoyer lift for all transfers and required physical assistance with management of medications and medical treatments. It identified facility staff provided management of medications and staff monitored the resident's skin for changes in condition.

R4's HCSP identified staff needed to complete a pressure ulcer risk assessment every six months and needed to "look over" his skin with bathing and provision of cares. He also had a wheelchair cushion.

The FCS/NSA and HCSP did not identify any interventions related to possible risk of skin breakdown.

Review of R4's "Electronic Progress Notes" revealed on 12/01/23 R4 developed a wound on his left ischium that was firm and had purulent drainage. R4 went to the emergency room for

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S3092	Continued From page 5 evaluation and then continued to go to the wound clinic for treatment of a pressure injury. Observation on 01/31/24 at 10:16 AM Administrative Licensed Nurse B went in to change R4's dressing to his left ischium. After propping the resident on his right side Administrative Licensed Nurse B removed the dressing, which revealed bloody drainage on the dressing. Administrative Licensed Nurse B then cleaned R4's wound, which revealed a clean wound bed with no slough identified. The wound measured 1.8 x 2 x 0.5 centimeters (cm) with tunneling at 7 o'clock and 5 o'clock less than 0.4 cm. Administrative Licensed Nurse B then cut the Medi-honey, shaped it to fit the wound, cut alginate to wound size and then covered it all with a foam dressing. On 01/30/24 at 04:00 PM Certified Medication Aide (CMA) C confirmed the resident had an open area on his bottom that is about the size of a quarter and the nurse changed the dressing every day. CMA C also reported the resident had barrier ointment that staff apply after using the toilet. CMA C stated he could move around in the bed, but he doesn't really reposition himself when we encourage him to do so. On 01/31/24 at 11:20 AM Administrative Licensed Nurse B acknowledged she should have completed a revision of the NSA to identify the resident had a pressure wound and received services related to prevention and healing of the wound. The operator failed to ensure designated staff reviewed and revised R4's NSA when he developed a pressure wound on his left ischium.	S3092		

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S3155	Continued From page 6	S3155		
S3155 SS=D	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of 37 residents (R). The sample included three residents and two focused record reviews. Based on observation, interview, and record review the executive director failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services for one (R4) of two sampled residents related to pressure wound management. Findings included: - R4's Electronic Medical Record revealed he moved into the facility on 03/17/21 with diagnosis of peripheral vascular disease, right below the knee amputation and left above the knee amputation. On 01/29/24 at 04:30 PM Administrative Staff A reported the "Functional Capacity Screen" and	S3155		

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S3155	Continued From page 7	S3155		

"Negotiated Service Agreement" were one document (FCS/NSA) and the "Health Care Service Plan" (HCSP) was a separate document.

R4's most current FCS/NSA dated 09/13/23 revealed the resident needed physical assistance with all activities of daily living except for eating. He used a hoyer lift for all transfers and required physical assistance with management of medications and medical treatments. It identified facility staff provided management of medications and staff monitored the resident's skin for changes in condition.

R4's HCSP identified staff needed to complete a pressure ulcer risk assessment every six months and needed to "look over" his skin with bathing and provision of cares.

The HCSP lacked interventions related to R4's pressure ulcer to help promote healing and prevent the development of additional pressure wounds.

Review of R4's electronic progress notes revealed that on 12/01/23 R4 developed a wound on his left ischium that was firm and had purulent drainage. R4 went to the emergency room for evaluation and then continued to go to the wound clinic for treatment of a pressure injury.

Observation on 01/31/24 at 10:16 AM Administrative Licensed Nurse B went in to change R4's dressing to his left ischium. After propping the resident on his right side Administrative Licensed Nurse B removed the dressing which revealed bloody drainage on the dressing. Administrative Licensed Nurse B then cleaned R4's wound which revealed a clean wound bed with no slough identified. The wound

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S3155	Continued From page 8 measured 1.8 x 2 x 0.5 centimeters (cm) with tunneling at 7 o'clock and 5 o'clock less than 0.4 cm. Administrative Licensed Nurse B then cut the Medi-honey, shaped it to fit the wound, cut alginate to wound size and then covered it all with a foam dressing. On 01/30/24 at 04:00 PM Certified Medication Aide (CMA) C confirmed the resident had an open area on his bottom that is about the size of a quarter and the nurse changed the dressing every day. CMA C also reported the resident had barrier ointment that staff apply after using the toilet. CMA C stated he could move around in the bed, but he doesn't really reposition himself when we encourage him to do so. On 01/31/24 at 11:20 AM Administrative Licensed Nurse B acknowledged she should have completed a revision of the NSA to identify the resident had a pressure wound and received services related to prevention and healing of the wound. The operator failed to ensure a licensed nurse developed and coordinated interventions related to the resident's development of a pressure wound.	S3155		
S3200 SS=D	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards	S3200		

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S3200	Continued From page 9 of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (d) The facility reported a census of 37 Residents (R). The sample included three residents and two focused record reviews. Based on interview and record review the operator failed to ensure qualified staff administered as needed (PRN) blood pressure medication and PRN sliding scale insulin according to physician's orders for R3. Findings included: - R3's Electronic Medical Record revealed she moved into the facility on 11/10/17 with diagnoses of dementia with behavioral disturbance and dysphagia (swallowing difficulty). On 01/29/24 at 04:30 PM Administrative Staff A reported the "Functional Capacity Screen" and "Negotiated Service Agreement" were one document (FCS/NSA) and the "Health Care Service Plan" (HCSP) was a separate document. All documents are signed by the licensed nurse and resident/legal representative.	S3200		

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S3200	Continued From page 10 R3's FCS/NSA dated 11/28/23 revealed she was not able to manage her medication administration and needed physical assistance with management of medical treatments. It identified the nurse prepared and administered all medications according to physicians' orders. R3's HCSP dated 11/28/23 revealed Certified Medication Aides/Licensed Nurses (LN) administered medications, the LN administered insulin, and staff checked her blood sugars as ordered. Review of R3's physician's orders included an order dated 09/15/22 to check R3's blood sugars three times a day and then clarified on 02/07/23 to check blood sugar before meals. She had an order dated 01/12/23 for sliding scale insulin: give 2-units for blood sugar 150 milligrams (mg) per deciliter (dL) - 200 mg/dl; give 3-units for blood sugar 201mg/dl-250 mg/dl; give 4-units for blood sugar 251 mg/dl-300 mg/dl; give 5-units for blood sugar 301 mg/dl-350 mg/dl and to call the physician if greater than 350 mg/dl. R3 also had a physician's order dated 01/18/20 for staff to monitor R3's blood pressure in the evening and administer PRN Clonidine (antihypertensive) for systolic blood pressure greater than 180 millimeter of mercury (mmHg) or if the diastolic blood pressure greater than 90 mmHg. Review of R3's December 2023 and January 2024 Medication Administration Record (MAR) / Treatment administration Record (TAR) revealed 16 times R3's blood sugar was greater than 150 mg/dl, with three times greater than 200 mg/dl and once greater than 350 mg/dl. The record lacked documentation of staff administering the PRN sliding scale insulin as ordered for any of the out-of-range readings for December 2023.	S3200		

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S3200	Continued From page 11 Review of R3's December 2023 MAR/TAR revealed the following elevated blood pressures without staff documentation of administering PRN Clonidine: 12/12/23 - 194/77 mmHg, 12/25/23 152/93 mmHg, 12/26/23 183/98 mmHg. Review of R3's January 2024 MAR/TAR revealed 25 times R3's blood sugar was greater than 150 mg/dl and five of those times it was greater than 200 mg/dl. The record lacked documentation of staff administering the PRN sliding scale insulin as ordered for any of the out-of-range readings in January 2024 except for 01/25/24 at noon for a reading of 246 mg/dl. Review of R3's January MAR/TAR revealed on 01/04/24 R3's blood pressure read 180/90 mmHg and staff administered the PRN Clonidine when it should not have been administered according to physician parameters. On 01/30/24 at 01:24 PM Administrative Licensed Nurse reviewed R3's December and January MAR/TAR and confirmed the sliding scale insulin and the PRN Clonidine was not administered according to physician ordered parameters. The operator failed to ensure the facility staff administered R3's sliding scale insulin and PRN Clonidine in accordance with a medical providers written order.	S3200		
S3290 SS=D	26-41-206 (a) (b) Dietary Services (a) Provision of dietary services. The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision or coordination of dietary	S3290		

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S3290	Continued From page 12	S3290		

services to residents as identified in each resident ' s negotiated service agreement. If the administrator or operator of the facility establishes a contract with another entity to provide or coordinate the provision of dietary services to the residents, the administrator or operator shall ensure that entity ' s compliance with these regulations.
(b) Staff. The supervisory responsibility for dietetic services shall be assigned to one employee.
(1) A dietetic services supervisor or licensed dietician shall provide scheduled on-site supervision in each facility with 11 or more residents.
(2) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-206(b)(2)

The facility reported a census of 37 Residents (R). The sample included three residents and tw focused record review. Based on observation, interview, and record review the operator failed to ensure one of three sampled residents (R3) received a pureed diet according to the residents' medical providers orders and registered dietitian approved recipes.

Findings included:

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S3290	Continued From page 13 - R3's Electronic Medical Record revealed she moved into the facility on 11/10/17 with diagnoses of dementia with behavioral disturbance and dysphagia (swallowing difficulty). On 01/29/24 at 04:30 PM Administrative Staff A reported the "Functional Capacity Screen" and "Negotiated Service Agreement" were one document (FCS/NSA) and the "Health Care Service Plan" (HCSP) was a separate document. All documents are signed by the licensed nurse and resident/legal representative. R3's FCS/NSA dated 11/28/23 revealed she needed supervision with eating, had impaired cognition, and received a mechanically altered diet with thickened liquids. R3's HCSP dated 11/28/23 revealed she was to receive a pureed diet with honey thickened liquids and staff were to remind her to swallow before eating. R3's Electronic Record included a medical providers order dated 10/9/23 for the resident to have pureed diet with honey thickened liquids. On 01/29/24 at 4:00 PM Certified Medication Aide (CMA) G reported breakfast was prepared on the memory care unit and the other meals were prepared in the main kitchen and brought down and served to residents. Observation on 01/30/24 at 09:15 AM R3 sat at the table in her wheelchair wiping scrambled eggs off her pants. All around her wheelchair were clumps of dry scrambled eggs. On 01/30/24 at 9:30 AM Activity Staff E reported	S3290		

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for breakfast she prepared R3 a bowl of oatmeal and sausage with scrambled eggs mixed in the chopper, and then a bowl of fruit mixed in the chopper.

On 01/30/24 at 09:37 AM Licensed Nurse (LN) F stated she served the resident scrambled eggs this morning and she was on a pureed diet. LN F stated she did not think there were any directions in the memory care on how to prepare a pureed diet.

Review of the "Diet Book" in the main kitchen revealed R3 received a regular diet pureed consistency with nectar thickened liquids.

Review of the "Recipe Book" included a section on pureed diets for how to puree each meal for each day. The meal for today was not in the recipe book, however the directions on all recipes included the following directions: "If the product needs thinning, gradually add an appropriate amount of liquid (NOT WATER) to achieve a smooth, pudding or soft mashed potato consistency... top with appropriate sauces or gravies as needed to ensure adequate moisture for safe consumption and enhanced flavor".

Observation on 01/30/24 at 11:50 AM Dietary Staff H brought the foods down for memory care including R3's "pureed" meal. When CMA I saw the "pureed" food in the bowels she stated it was not pureed enough and needed to be more "watery' and not chunky. Dietary Staff H took the bowls over to the food chopper and put the potatoes in the chopper. He got a glass with some water in it and poured some water in it and then turned on the machine. Observation revealed pieces of potato peeling in the mixture and explained that she would not be able to eat it

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S3290	Continued From page 15 with peeling. Dietary Staff H then cleaned out the container and put the sausage in it and added a little water and turned on the chopper and then did the same with the green beans. At 12:09 Dietary Staff H returned to the main kitchen and picked potatoes out of a couple other wrapped meals and took the peelings off and added it to the food chopper. He poured a little water in the chopper a couple of times to make it a smoother consistency. On 01/30/24 at 12:12 PM Dietary Staff J reported if she needed to thin a food item she would use gravy or something, but are not supposed to use water. The operator failed to ensure dietary staff served R3 a pureed diet as ordered and according to the pureed recipe guidance.	S3290		
S3298 SS=F	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations. (2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws	S3298		

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S3298	Continued From page 16 and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(d) The facility reported a census of 37 residents. Based on observation, interview, and record review the operator failed to ensure dietary staff monitored food temperatures to ensure it was prepared and served at the proper temperature. Findings included: - During initial tour on 01/29/24 at 03:59 PM Certified Medication Aide (CMA) G reported breakfast is prepared to order in the memory care unit and lunch and supper are prepared in the main kitchen and brought down to the memory care unit. CMA G did not know anything about taking food temperatures and there was not a log on the memory care unit for preparing breakfast foods. Review of the "Food Temperature Logs" in the main kitchen for December 2023 and January 2024 revealed the following: The December log lacked any documentation for breakfast, seven out of fourteen lunch meals had no food temperatures, and two out of seven suppers had no food temperatures documented. The January log included the whole month, but lacked documentation for any breakfast foods, sixteen out of twenty-nine lunch meals lacked documentation of food temperatures, and nine out of twenty-nine suppers had no documentation	S3298		

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of food temperatures.

Observation on 01/30 24 at 09:41 AM Certified Nurse Aide (CNA) K put on gloves and then took two waffles out of a package that sat on the counter and put them in the toaster. She then got two plates out of the cabinet, took a couple of pieces of bacon off a plate covered with a paper towel that had been sitting on the counter, and put some on each plate. She then prepared coffee with sweetener and water and took it to a resident. CNA K then took the waffles out of the toaster, butter them, and cut them up into pieces and gave them to residents at the table.

On 01/30/24 at 09:48 AM CNA K reported the bacon was prepared earlier this morning and did not know how long it had been sitting out on the counter.

On 01/30/24 at 09:56 AM Activity staff E confirmed she had prepared the bacon and had taken out the last pan of bacon around 08:15 AM

Observation on 01/30/24 at 11:50 AM Dietary Staff H had brought the noon meal down for memory care including R3's "pureed" meal. The meal consisted of sausage, red potatoes, and green beans. When CMA I saw the "pureed" food in the bowels she stated it was not pureed enough and needed to be more "watery" and not chunky. When Dietary Staff H reprocessed R3's food he added water from the kitchen sink to each food item and did not temp the food prior to serving it to R3.

On 01/30/24 at 04:15 PM Administrative Staff A acknowledged staff needed to take the temperature of foods to ensure they are cooked to the proper temperature and served at the

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S3298	Continued From page 18 proper temperatures. The operator failed to ensure dietary staff monitored food cooking and serving temperatures to ensure it was prepared and served at the proper temperature.	S3298		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(e) The facility reported a census of 37 residents. Based on observation and interview the operator failed to ensure designated staff stored all food under safe and sanitary conditions. Findings included: - Observations during the kitchen tour on 01/30/24 at 09:57 AM revealed in the double freezer, two baggies of fish patties that did not have a date on them. It contained an unlabeled bag of steak fingers, an unlabeled bag of chicken patties, and another bag labeled hamburger (patties) that did not include a date opened or a use by date. The double refrigerator contained grocery bags with employee food items on the right side with some food items dated and labeled	S3299		

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S3299	Continued From page 19 and some not. In tub on the bottom shelf, it contained two chubs of hamburger not dated or labeled, a processed ham, packages of chicken strips all thawing in the same tub. In the white refrigerator/freezer contained a baggie in the freezer with eight sausage patties without a date on them or label on them. On 01/30/24 at 10:01 AM Dietary Staff D reported all items in the freezer that are open or out of original packaging need to be labeled and dated. Review of the ""Focus on Food Safety" guidance from the Kansas Department of Agriculture revised August 2017 directs foods that are prepared on-site or commercially processed need to be date marked after the original container is opened and held under refrigeration, potentially hazardous foods, ready to eat foods, and foods held for more than 24 hours need to be date marked. The operator failed to ensure designated staff stored foods in manner to ensure they were sealed, dated, and labeled when stored in the refrigerator or freezer according to food safety guidelines.	S3299		
S3305 SS=F	26-41-207 (a) (b) Infection Control (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a safe, sanitary, and comfortable environment for residents. (b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements:	S3305		

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S3305	Continued From page 20 (1) Using universal precautions to prevent the spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards; (4) providing sanitary conditions for food service; (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (7) transferring a resident with an infectious disease to an appropriate health care facility if the administrator or operator is unable to provide the isolation precautions necessary to protect the health of other residents. This REQUIREMENT is not met as evidenced by: KAR 26-41-207 (b)(4) The facility reported a census of 37 residents. Based on observations and interview the operator failed to ensure staff implemented procedures to prevent the spread of infections by the failure to ensure dietary staff used proper glove usage and food service techniques as they prepared plates for residents. Findings included:	S3305		

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S3305	Continued From page 21 - Observation on 01/30 24 at 09:41 AM Certified Nurse Aide K put on gloves and then took two waffles out of a package that sat on the counter and put them in the toaster. With the same gloved hands, she then got two plates out of the cabinet, took a couple of pieces of bacon off a plate covered with a paper towel that had been sitting on the counter and put some on each plate. Without changing her gloves, she then prepared coffee with sweetener and water and took it to a resident. CNA K then took the waffles out of the toaster, butter them, and cut them up into pieces, put syrup on them, and gave them to residents at the table, all without changing her gloves. Observation on 01/30/24 at 11:40 AM Dietary Staff H pushed the cart with lunch on it to the memory care unit wearing gloves. He opened the kitchen door and then got plates out of the kitchen cabinet to put the food on. He unwrapped the "hobo dinners" (sausage, small red potatoes with peelings and green beans wrapped in foil) and laid them on the plate. Certified Medication Aide I asked him to put them on the plate without the foil or in a bowl to make sure none of the residents accidently ate some of the foil. Dietary Staff H then got bowls out of the kitchen cabinet with the same gloves on he had on while pushing down the cart. He unwrapped the foil and then took his gloved hand and scooped the food off the foil and into the bowl. He tried to dump it into the bowl without touching the food a few times but spilt the food on the counter and then picked it up off the counter and put it in the bowl. Part of the meal included muffins, which he took out of the pan with the same gloved hands. At 11:53 AM after all the "regular" plates were served, he got the ice cream scoop and the ice cream off the	S3305		

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S3305	Continued From page 22 cart and put the pan of brownies on the counter. With the same gloved left hand, he scooped out a piece of brownie and put it on a plate and then put a scoop of ice-cream on top. He used his gloved hand to plate all the brownies instead of using a serving utensil. On 01/30/24 at 04:15 PM the surveyor discussed with Administrative Staff A the usage of the same gloves that touched potentially contaminated items and then touching ready to eat food and she acknowledged staff are to wash their hands and change gloves as needed. The operator failed to ensure dietary staff served foods using techniques to ensure the prevention of the spread of infections by the failure of staff to properly use gloves.	S3305		