STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089045	A. BUILDING: _____ B. WING _____	07/25/2023

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LEGEND AT CAPITAL RIDGE	1931 SW ARVONIA PLACE TOPEKA, KS 66615

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a Re-Licensure Survey with complain investigations 175815, 176354, 178898, and 180129 for the above named assisted living facility conducted on 07/24/23 and 07/25/23.	S 000		
S3080 SS=D	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(a) The facility reported a census of 57 residents(R). The sample included three residents and four focused record reviews. Based on interview and record review the administrator failed to ensure one (R6) of three sampled residents had a "Functional Capacity Screen" completed by designated staff on or before admission to the	S3080		

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

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S3080	Continued From page 1 assisted living facility to determine the resident's functional capacity. Findings included: - Review of R6's medical record revealed he moved into the facility on 06/15/22 with diagnosis of Alzheimer's disease. R6's record included an admission "Functional Capacity Screen" signed and dated on 06/16/23, the day after admission to the facility. On 07/26/23 at 9:53 AM, Administrative Licensed Nurse B acknowledged the resident moved into the facility on 06/15/22 and his "Functional Capacity Screen" should have been done no later than the day that he moved in to the facility. The administrator failed to ensure designated staff completed an admission Functional Capacity Screen for R6, on or before admission to the facility.	S3080		
S3081 SS=E	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity 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; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant.	S3081		

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S3081	Continued From page 2 This REQUIREMENT is not met as evidenced by: KAR 26-41-201 (c)(2) The facility reported a census of 57 residents (R). The sample included three residents and four focused record reviews. Based on observation, interview, and record review the operator failed to ensure staff completed a "Functional Capacity Screen" for one (R3) of three sampled residents at least every 365 days or when she experienced a significant change in status. . Findings Included: - Review of R3's medical record revealed she moved into the facility on 02/28/21with diagnoses of dementia. R3's most current "Functional Capacity Screen" (FCS) dated 05/04/21 revealed the resident was independent with all activities of daily living but was unable to manage her medications and medical treatments and had cognitive impairment. The designated staff failed to complete a new FCS when the resident experienced a significant change in status and did not complete one within 365 days. Review of R3's resident notes revealed on 04/01/22 she refused oral intake and on 04/04/23 she was too weak to walk. On 04/19/22 she signed onto Hospice services, had an indwelling catheter inserted and had a decreased level of consciousness. On 04/25/22 the resident needed assistance of two staff for transfers and had a	S3081		

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S3081	Continued From page 3 wound on her right heel. On 07/25/23 at 02:16 PM Administrative Licensed Nurse B reported the Functional Capacity Screens should have been completed when she had a significant decline in status. The administrator failed to ensure designated staff completed a Functional Capacity screen for R3 when she had a significant decline in her functional ability.	S3081		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (a)(1)(2)(3)	S3085		

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S3085	Continued From page 4 The facility reported a census of 57 residents (R). The sample included three residents and four focused record reviews. Based on record review and interview for one (R6) of three sampled residents and one (R4) of four focused reviews, the administrator failed to ensure designated staff completed the "Negotiated Service Agreement" based on the resident's "Functional Capacity Screen" and service needs, which included a description of the service provided, identification of "who" provided the service and if provided by an outside source who was responsible for payment of the service. Findings included: - Review of R4's medical record revealed she moved into the facility on 9/30/23 with a diagnosis of Alzheimer's disease. R4's "Functional Capacity Screen" (FCS) dated 10/3/22 revealed she required physical assistance with bathing, dressing and management of medications and medical treatments. She also required supervision with toileting, transfers, and walking/mobility. She had impaired cognition, had a current problem or risk for falls, impaired vision, impaired hearing, and wandering. On 07/25/23 AT 9:42 AM Administrative Licensed Nurse B reported the "Negotiated Service Agreement" and the "Health Care Service Plan" (NSA/HCSP) are one document. R4's "Negotiated Service Agreement/Health Care Service Plan" dated 10/03/22 failed to address	S3085		

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S3085	Continued From page 5	S3085		

services related to falls/unsteadiness, impaired vision and hearing and her wandering. It also failed to include the resident received podiatry services from an outside resource, who provided the service and who was responsible for payment of the service.

7/26/23 at 01:06 PM Administrative Licensed Nurse B acknowledged the NSA/HCSP needed to identify services related to the resident needs on the FCS as well as including the outside service for Podiatry.

The administrator failed to ensure designated staff included a description of the services the resident received based upon the FCS and service needs as well as including who provided the service and who was responsible for the service if it was provided by an outside resource.

- Review of R6's medical record revealed he moved into the facility on 06/15/22 with diagnosis of Alzheimer's disease.

R6's most current "Functional Capacity Screen" dated 06/09/23 identified the resident needed physical assistance with bathing, dressing, toileting and supervision with transfers and mobility. He needed physical assistance with medication management and medical treatments, had impaired cognition and communication abilities, and was at risk for falls. He also had impaired vision and hearing.

On 07/25/23 AT 09:42 AM Administrative Licensed Nurse B reported the "Negotiated Service Agreement" and the "Health Care

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S3085	Continued From page 6 Service Plan" (NSA/HCSP) are one document. R6's most current "Negotiated Service Agreement/Health Care Service Plan" initiated on 06/09/23 failed to include services related to communication problems, falls, impaired vision and hearing and his wandering. It failed to include a description for these services, who provided the service and failed to include he received podiatry services from an outside source. On 07/26/23 at 09:55 AM Administrative Licensed Nurse B reported the NSA/HCSP should have addressed the resident needs and preferences identified on the Functional Capacity Screen and should have included podiatry services. The administrator failed to ensure a licensed nurse developed the NSA/HCSP for R6 to include a description of service needs as identified on the resident's "Functional Capacity Screen", including who provided the service and if provided by an outside resource who was responsible for payment of the service.	S3085		
S3090 SS=D	26-41-202 (c) Admission Negotiated Service Agreement (c) Each administrator or operator shall ensure the development of an initial negotiated service agreement at admission. This REQUIREMENT is not met as evidenced	S3090		

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S3090	Continued From page 7 by: KAR 26-41-202(c) The facility reported a census of 57 residents(R). The sample included three residents, four focused record reviews. Based on interview and record review the administrator failed to ensure one (R6) of three sampled residents had an initial "Negotiated Service Agreement" completed at admission. Findings included: - Review of R6's medical record revealed he moved into the facility on 06/15/22 with diagnosis of Alzheimer's disease. R6's record included an admission "Negotiated Service Agreement/Health Care Service Plan" signed and dated on 06/16/23, the day after admission to the facility. . On 07/26/23 at 09:53 AM, Administrative Licensed Nurse B acknowledged the resident moved into the facility on 06/15/22 and his "Negotiated Service Agreement/Health Care Service Plan" should have been done no later than the day that he moved in to the facility. The administrator failed to ensure designated staff completed an admission Negotiated Service Agreement for R6, on or before admission to the facility.	S3090		
S3092 SS=E	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure	S3092		

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S3092	Continued From page 8	S3092		

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 57 residents (R). The sample included three residents and four focused record reviews. Based on interview and record review the administrator failed to ensure designated staff reviewed and revised the combined "Negotiated Service Agreement/Health Care Service Plan" if necessary, for one (R6) of three sampled residents and one (R3) of four focused resident records reviewed who experienced a significant change in status.

Findings included:

- Review of R3's medical record revealed she moved into the facility on 02/28/21 with diagnoses of dementia.

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R3's most current "Functional Capacity Screen" (FCS) dated 05/04/21 revealed the resident was independent with all activities of daily living but was unable to manage her medications and medical treatments and had cognitive impairment.

On 07/25/23 AT 09:42 AM Administrative Licensed Nurse B reported the "Negotiated Service Agreement" and the "Health Care Service Plan" (NSA/HCSP) are one document.

Review of R3's NSA/HCSP dated 05/17/23 revealed the resident brought herself down to all meals and that Certified Medication Aides and Licensed Nurses manage and administer the resident's medications.

Review of R3's medical record revealed she admitted to Home Health on 03/23/22 and on 04/19/22 she admitted to Hospice services.

R3's skin observation notes revealed on 04/19/22 she had a Deep Tissue Injury (pressure-related injury to subcutaneous tissues under intact skin), she was bed fast and completely immobile.

Review of R3's resident notes revealed on 04/01/22 she refused oral intake and on 04/04/23 she was too weak to walk. On 04/19/22 she signed onto Hospice services, had an indwelling catheter inserted and had a decreased level of consciousness. On 04/25/22 the resident needed assistance of two staff for transfers and had a wound on her right heel.

On 07/25/23 at 02:16 PM Administrative

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S3092	Continued From page 10	S3092		

Licensed Nurse B reported the NSA/HCSP should have been revised when she had a significant decline in status.

The administrator failed to ensure designated staff revised R3's NSA/HCSP when experienced a significant decline in status and required increased service needs.

- Review of R6's medical record revealed he moved into the facility on 06/15/22 with diagnosis of Alzheimer's disease.

R6's most current "Functional Capacity Screen" dated 06/09/23 identified the resident needed physical assistance with bathing, dressing, toileting and supervision with transfers and mobility. He needed physical assistance with medication management and medical treatments, had impaired cognition and communication abilities, and was at risk for falls.

On 07/25/23 AT 09:42 AM Administrative Licensed Nurse B reported the "Negotiated Service Agreement" and the "Health Care Service Plan" (NSA/HCSP) are one document.

R6's most current "Negotiated Service Agreement/Health Care Service Plan" initiated on 06/09/23 identified qualified staff provided physical assist with showers twice a week and Hospice provided those showers, was provided minimal assistance with dressing and was independent at times with toileting but staff needed to cue and prompt resident. Certified medication aides and Licensed Nurses administered medications and treatments - staff prompted and cued resident related to his

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S3092	Continued From page 11 impaired cognition. Facility staff failed to review/revise his NSA when he developed a wound and required dressing changes and repositioning to help promote healing. The resident's notes included on 06/25/23 he had a non-blanchable area to his coccyx that measured .1 x .2 cm (centimeters) and was beefy read. On 06/30/23 the area remained open, the same size with macerated edges. The resident needed to continue to be repositioned side to side and continue foam dressing to be applied to the area every 3 days. Observation on 07/25/23 at 03:07 PM the Hospice nurse and Administrative Licensed Nurse rolled the resident onto his right side to complete his treatment. When staff had pulled down his pants to expose his wound it revealed an open area the size of an eraser on the end of a pencil, and there was no dressing on the wound. On 07/26/23 at 10:02 AM Administrative Licensed Nurse B acknowledged she should have either done an addendum or revised the current NSA when he developed a wound on his coccyx and needed additional services related to wound care and healing. The administrator failed to ensure designated staff reviewed and revised R6's NSA/HCSP when he developed a pressure wound on his coccyx and required additional services to meet his needs.	S3092		
S3102 SS=E	26-41-202 (i) Negotiated Service Agreement Service Received	S3102		

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S3102	Continued From page 12 (i) Each administrator or operator shall ensure that each resident receives services according to the provisions of that resident ' s negotiated service agreement This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (i) The facility reported a census of 57 residents (R). The sample included three residents and four focused record reviews. Based on interviews and record review, the administrator failed to ensure the provision of adequate staffing to ensure each resident who required assistance of staff for toileting, bathing, dressing, and medication administration received those services according to the resident's "Negotiated Service Agreement/Health Care Service Plan" in a timely manner. Findings Included: - During an interview on 07/24/23 at 10:37 AM Administrative Licensed Nurse B reported the following staff in the facility: First shift there are four to nine staff on the assisted living side and two on the memory care side. For second shift there are three on the assisted living side and two on memory care side. On night shift there are 3-4 in the building with one always in memory care. - Review of the facility call light record revealed the following call light times on the following days: 03/06/23 - 26 call lights went unanswered for	S3102		

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S3102	Continued From page 13 11-29 minutes and four call lights went unanswered for 30 minutes or longer. 03/12/23 - 19 call lights went unanswered for 11-29 minutes and four call lights went unanswered for 30 minutes or longer. 03/19/23 - 30 call lights went unanswered for 11-29 minutes and six call lights went unanswered for 30 minutes or longer. 03/26/23 - 23 call lights went unanswered for 11-29 minutes and 14 call lights went unanswered for 30 minutes or longer. Four of those lights went unanswered for over one hour. 03/30/23 - 19 call lights went unanswered for 11-29 minutes and seven call lights went unanswered for 30 minutes or longer. 07/03/23 - 27 call lights went unanswered for 11-29 minutes and seven call lights went unanswered for 30 minutes or longer. 07/06/23 - 38 call lights went unanswered for 11-29 minutes and four call lights went unanswered for 30 minutes or longer. 07/10/23 - 25 call lights went unanswered for 11-29 minutes and seven call lights went unanswered for 30 minutes or longer. Two of those lights went unanswered for over one hour. 07/14/23 - 33 call lights went unanswered for 11-29 minutes and five call lights went unanswered for 30 minutes or longer. 07/23/23 - 39 call lights went unanswered for 11-29 minutes and 10 call lights went unanswered for over 30 minutes. Interviews with seven alert and oriented residents reported the following concerns related to call light response time and insufficient staffing. Residents report they did not get morning	S3102		

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S3102	Continued From page 14	S3102		

medications timely, did not always get a shower when they were supposed to, and waited long periods of time for staff to answer call lights resulting in urinary incontinent episodes.

Interview with two residents' DPOAs reported the same concerns that the residents reported.

During confidential interviews, Certified Nurse Aides (CNA) and Certified Medication Aides (CMA) reported the following:
1. It depends on who is working if everything gets done and call lights get answered timely. Sometimes the CMAs do not help answer call lights so the residents have to wait a long time for help.
2. Medications do not always get passed within the allotted time frame because there is not enough staff to answer call lights.
3. We have the same number of staff we did a year ago and we have a lot more residents. Showers do not get done when they are supposed to and we often have to rush to get basic care done. There have been a lot of resident complaints for not getting call lights answered, we do not get medications passed timely because we have to answer resident call lights.
4. When I first started there were two CMAs and two CNAs, and we got new residents and are supposed to have three CNAs and two CMAs but that doesn't happen. Showers do not get done and sometimes it takes us 30 minutes or longer to answer a call light.
5. Staff stated they probably do not get everything done that is assigned to be done according to their service plans. Staff also stated physician orders do not get put into the

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S3102	Continued From page 15 electronic medication record timely, and residents do not get medications passed timely. Sometimes morning medications scheduled for 08:00 AM do not get passed until 10:00 or 11:00 AM. Staff also reported on 07/23/23 there were only two staff on the floor until noon when the nurse came in to help. Review of the July 2023 schedule revealed on 07/23/23 there were only four staff for the entire building who were on the schedule to work, and the Nurse picked up the shift as well. 07/25/23 at 01:52 PM Administrative Licensed Nurse B reported there are times they have plenty of staff scheduled and they either call in or don't show up. She acknowledged that staffing had been an issue and that was why she worked almost every day by coming in to help. Review of the "Scheduling and Staffing" policy dated 12/01/12 revealed: "There will be adequate staff on duty at all times to meet the scheduled and unscheduled needs of the residents." The administrator failed to ensure the provision of adequate staffing to ensure each resident who required assistance of staff for toileting, bathing, dressing, and medication administration received those services according to the resident's "Negotiated Service Agreement/Health Care Service Plan" in a timely manner.	S3102		
S3166 SS=E	26-41-204 (e) Delegation of Duties (e) A licensed nurse may delegate nursing procedures not included in the nurse aide or	S3166		

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S3166	Continued From page 16 medication aide curriculums to nurse aides or medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(e) The facility reported a census of 57 residents. Based on interview and record review the administrator failed to ensure three of three sampled Certified Medication Aides (CMA) were trained by a licensed nurse and delegated the nursing procedure for obtaining blood glucose checks according to the nurse practice act and amendments thereto. Findings included: - On 07/24/23 at 10:45 AM during completion of entrance checklist, Administrative Licensed Nurse B reported the Certified Medication Aide is the one who checks resident's blood sugars. On 07/24/23 surveyor had requested delegation/competency checks for Certified Medication Aide (CMA) E, CMA F, and CMA I. On 07/24/23 at 01:48 PM Administrative Staff C reported the facility did not have delegation/competency completed for the CMA to be able to monitor resident's blood glucose via glucometer.	S3166		

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S3166	Continued From page 17 The administrator failed to ensure a licensed nurse delegated the nursing procedure of checking a resident's blood glucose via glucometer according to the nurse practice act, KSA 65-1124 and amendments thereto.	S3166		
S3202 SS=E	26-41-205 (d) (4) Delegation of Medication Administration (4) Any licensed nurse may delegate nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d)(4) The facility reported a census of 57 residents. Based on interview and record review the administrator failed to ensure three of three sampled Certified Medication Aides (CMA) were trained by a licensed nurse and delegated the nursing procedure of preparing and dialing an insulin pen to the ordered dosage for a resident to then self-inject, which is not a part of the CMA curriculum. Findings included: - On 07/24/23 at 10:45 AM during completion of entrance checklist, Administrative Licensed Nurse B reported the Certified Medication Aide prepares the insulin pen and dials it to the ordered dosage and hands it to the resident for them to self-inject.	S3202		

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S3202	Continued From page 18 On 07/24/23 surveyor requested delegation/competency checks for Certified Medication Aide (CMA) E, CMA F, and CMA I related to the preparation and dialing dosage for insulin pens. . On 07/24/23 at 01:48 PM Administrative Staff C reported the facility did not have delegation/competency completed for the CMAs to be able to prepare, prime, and dial an insulin pen to the proper dosage for the resident to then self-inject. The administrator failed to ensure the licensed nurse delegated the nursing procedure of preparing and dialing the dosage of an insulin pen, which is not included in the CMA curriculum, to three of three newly hired CMAs who had prepared insulin pens for residents to self-inject.	S3202		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container.	S3211		

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S3211	Continued From page 19 This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g)(3) The facility reported a census of 57 residents. Based on observation and interview, the administrator failed to ensure all over-the-counter medications were labeled with the resident's full name. This includes the need for the resident's full name to be on the original manufacturer's medication package and the medication container/insert. Findings included: - During initial tour of the facility on 07/24/23 at 09:32 AM Certified Medication Aide (CMA) E opened the Hall 100 medication cart which revealed the following over-the-counter medications without a residents full name on them: a bottle of Vitamin C, bottle of PerserVision AREDS 2, bottle of Omega 3, and a bottle of Aspirin 81 milligrams. At 09:40 AM, CMA F unlocked the 200 hall medication cart which included the following over-the-counter medications without a residents full name on them: a bottle of PerserVision AREDS 2, 2 bottles of Vitamin B12, bottle of Magnesium, two bottles of Lutein, bottle of Artificial Tears and a bottle of Osteo Bi-flex. At 10:05 AM, CMA G unlocked the Memory Care medication cart for inspection which revealed the following: a bottle of woman's probiotic with a resident's first name only, a bottle of Aspirin 81	S3211		

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S3211	Continued From page 20 milligrams with the last name only, and a bottle of Zyrtec without a name on it. On 07/24/23 at 10:45 AM Administrative Licensed Nurse B reported all over-the-counter medications should have the resident's full name written on the bottle. The administrator failed to ensure all over-the-counter medications included the full name of the resident they belonged to and included the name on the original manufacturer's medication package and the medication container.	S3211		
S3215 SS=E	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to	S3215		

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S3215	Continued From page 21 the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (h) (4) The facility reported a census of 57 residents (R). Based on observation and interview the administrator failed to ensure licensed nurses and certified medication aides could not administer medications beyond the medication manufacturer's or pharmacy provider's recommended date of expiration by a failure to ensure staff dated insulin pens once opened. Findings included: - On 07/24/23 at 09:32 AM Certified Medication Aide (CMA) E unlocked the 100-hall medication cart for inspection. The cart included a Lantus insulin flex-pen with no name and no date written on the pen. CMA E stated she did not know when the pen was initially used. On 07/24/23 at 09:40 AM CMA F unlocked the 200-hall medication cart for inspection. The cart	S3215		

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included a Lantus insulin Flexpen and a Novolog insulin Flexpen. The Lantus Flexpen had 20 units remaining and the Novolog Flexpen was almost full. Neither pen had the date the pen was initially used and only one pen had the resident's name on it.

On 07/24/23 at 10:05 AM CMA G unlocked the Memory Care medication cart and stated there was no one on Memory Care who received insulin. The cart contained a Novolog Flexpen without a resident name on it and no date on when it was initially used. It had 210 units remaining.

According to the Lantus manufacture recommendations the Flexpen should be thrown away after 28 days even if insulin remains in the pen.
According to Novolog manufacturer recommendations the Flexpen should be thrown away after 28 days even if insulin remains in the pen.
On 07/24/23 at 10:45 AM Administrative licensed nurse B reported insulin pens needed to include the resident's name on the pen and the date initiated and the date to discard on the pen.

Review of the "Storage of Medications" policy dated 08/01/12 revealed all drugs managed by the facility shall be stored following manufacturer's recommendations and in accordance with federal and state laws and regulations.

The administrator failed to ensure licensed nurses and certified medication aides stored insulin Flexpens correctly to ensure they could

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S3215	Continued From page 23 not be administered beyond the medication manufacturer's recommended date of expiration by a failure to ensure staff dated insulin pens once they were punctured.	S3215		
S3220 SS=D	26-41-205 (k) Medication Clinical Record (k) Clinical record. The administrator or operator, or the designee, shall ensure that the clinical record of each resident for whom the facility manages medication or prefills medication containers or syringes contains the following documentation: (1) A medical care provider ' s order for each medication; (2) the name of the pharmacy provider of the resident ' s choice; (3) any known medication allergies; and (4) the date and the 12-hour or 24-hour clock time any medication is administered to the resident. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (k)(1) The facility reported a census of 57 residents (R) and the sample included three residents and four focused record reviews. Based on record review and interview the facility failed to ensure one (R8) of three sampled resident's medical record contained a medical care provider's order for each medication. Findings included:	S3220		

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S3220	Continued From page 24 - Review of R8's medical record revealed he moved into the facility on 12/14/21 with a diagnosis of atrial fibrillation. R8's "Functional Capacity Screen" dated 06/20/22 revealed the resident was unable to manage his medications and medical treatments. On 07/25/23 at 09:42 AM Administrative Licensed Nurse B reported the "Negotiated Service Agreement" and the "Health Care Service Plan" (NSA/HCSP) are one document. R8's NSA/HCSP dated 02/28/23 identified certified medication aides and licensed nurses would order and administer the resident's medications. Review of the resident record lacked a physician's order for the residents coumadin which the facility was responsible for administering. On 07/24/23 at 03:11 PM Administrative Licensed Nurse B reported the resident's family had not signed a release for the physician to share information with the facility. She stated the family takes the resident to all of his appointments and then will come back and tell us what the physician said. For his coumadin the family brought small calendars with the dosages written on for each day. She acknowledged that they did not have signed physician's orders for the resident's coumadin dosages. The administrator failed to ensure R8 had a medical providers order for each medication he received.	S3220		

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S3258 SS=F	26-41-105 (e) Electronic Medical Record (e) If electronic medical records are used, each administrator or operator shall ensure the development of policies addressing the following requirements: (1) Protection of electronic medical records, including entries by only authorized users; (2) safeguarding of electronic medical records against unauthorized alteration, loss, destruction, and use; (3) prevention of the unauthorized use of electronic signatures; (4) confidentiality of electronic medical records; and (5) preservation of electronic medical records. (f) Each resident record shall contain at least the following: (1) The resident's name; (2) the dates of admission and discharge; (3) the admission agreement and any amendments; (4) the functional capacity screenings; (5) the health care service plan, if applicable; (6) the negotiated service agreement and any revisions; (7) the name, address, and telephone number of the physician and the dentist to be notified in an emergency; (8) the name, address, and telephone number of the legal representative or the individual of the resident's choice to be notified in the event of a significant change in condition; (9) the name, address, and telephone number of the case manager, if applicable; (10) records of medications, biologicals, and treatments administered and each medical care provider ' s order if the facility is managing the resident's medications and medical treatments;	S3258		

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S3258	Continued From page 26 and (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. This REQUIREMENT is not met as evidenced by: KAR 26-41-105(e)(1)(2)(3)(4)(5) The facility reported a census of 65 residents. The sample included three residents and four focused record reviews. Based on observation, interview and record review the administrator failed to ensure the development of a policy regarding the use of electronic medical records that included the following: (1) Protection of electronic medical records, (2) safeguard against unauthorized alteration, loss, and destruction, (3) prevention of unauthorized use of electronic signatures, (4) maintaining confidentiality of electronic medical records, and (5) preservation of electronic medical records. Findings included: - During the survey process on tour on 07/25/23 at 09:04 AM surveyor walked down the hall on the computer on the 100 hall cart was open and information regarding medications orders, residents full name, and a picture of the resident were available for anyone to see. On 07/26/23 at 03:25 PM Administrative staff A and Administrative Licensed Nurse B acknowledged the staff were to close the computers when not at the medication carts to ensure protection and privacy of residents'	S3258		

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S3258	Continued From page 27 medication administration records. Surveyor requested a copy of the policy for electronic medical records from Administrative Staff A on 07/26/23 at 08:55 AM via electronic request with the following correspondence: On 07/27/23 at 09:41 AM Administrative staff A responded that they did not have electronic records. On 07/27/23 at 10:41 AM surveyor questioned Administrative Staff A "You have electronic MARs (Medication Administration Records) and whatever [name] documents, correct?" On 07/28/23 at 10:34 AM Administrative Staff A responded that he was working on a policy for electronic records. As of 07/31/23 at 11:20 AM Surveyor had not received a policy for electronic medical records. The administrator failed to develop a policy for the use of electronic medical records that covered all areas regarding protection of electronic medical records.	S3258		
S3261 SS=E	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by:	S3261		

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S3261	Continued From page 28 KAR 26-41-105(f)(11) The facility reported a census of 57 residents (R). The sample included three residents and four focused record reviews. Based on interview and record review the operator failed to ensure each resident record contained documentation of all incidents, symptoms, and other indications of illness or injury, what was done, and the results of action taken for one (R6) of three sampled residents and three (R3, R4, R5) of four focused record reviews. Findings included: - Review of R3's medical record revealed she moved into the facility on 02/28/21 with diagnoses of dementia. R3's most current "Functional Capacity Screen" (FCS) dated 05/04/21 revealed the resident was independent with all activities of daily living but was unable to manage her medications and medical treatments and had cognitive impairment. On 07/25/23 AT 09:42 AM Administrative Licensed Nurse B reported the "Negotiated Service Agreement" and the "Health Care Service Plan" (NSA/HCSP) are one document. Review of R3's NSA/HCSP dated 05/17/23 revealed the resident brought herself down to all meals and that Certified Medication Aides and Licensed Nurses manage and administer the resident's medications. Review of R3's resident notes revealed the	S3261		

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following:
01/12/22 - Medical provider in facility to see resident post fall. The residents record lacked documentation of the resident having a fall or follow up for potential injuries post fall.
02/01/22 - Medical provider in with new orders to discontinue Depakote (mood stabilizer), Folic Acid, Namenda (for dementia), Pantoprazole (gastric acid reducer), Quetiapine (antipsychotic), Exelon patch (dementia), Thiamine, Tylenol, Albuterol, Ativan (antianxiety), Zyprexa (antipsychotic) and to start Risperidone Consta (antipsychotic injectable). The record lacked follow up for any adverse effects the resident may have had related to the discontinuation of multiple medications at one time.
02/25/22 - Lump discovered in right breast and started on antibiotic for abscess. The record lacked follow up as to the lump and if it cleared after antibiotics.
03/30/22 - Resident with increased pitting edema with order to increase Lasix (diuretic) to twice a day. The record lacked follow up as to the effectiveness of the medication reducing the resident's edema.

All of the above notes were handwritten and lacked documentation of the time staff documented in the resident record.

On 07/25/23 at 02:16 PM Administrative Licensed Nurse B reported the resident notes needed to include any changes in states, medication, or treatment changes, follow up on any changes and falls as well as notification of family and physician. Administrative Licensed Nurse B acknowledged that she knew she had

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LEGEND AT CAPITAL RIDGE	1931 SW ARVONIA PLACE TOPEKA, KS 66615

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not documented in the record as she should have and acknowledged the handwritten notes did not include times that she put the notes in the record.

Review of the "Documentation" policy dated 07/19/22 revealed the "Healthcare Coordinator" is responsible for accurate and timely documentation in the resident record. Documentation will be based upon personal observation, action and communication and will document pertinent information.

The administrator failed to ensure designated staff documented the date and time of all incidents, symptoms, and other indications of illness or injury, what was done, and the results of action taken for R3.

- Review of R4's medical record revealed she moved into the facility on 09/30/21 with a diagnosis of Alzheimer's disease.

R4's "Functional Capacity Screen" dated 10/03/22 revealed she needed physical assistance with bathing and dressing and medication management. She also had impaired cognition, at risk for falls, had impaired vision and hearing and wandered.

On 07/25/23 AT 09:42 AM Administrative Licensed Nurse B reported the "Negotiated Service Agreement" and the "Health Care Service Plan" (NSA/HCSP) are one document.

R4's NSA/HCSP included services for dressing, bathing, medication management and cognition.

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S3261	Continued From page 31 Review of R4's resident notes from 04/6/22 to 10/25/22 were all handwritten and did not include the time staff documented and revealed the following: 04/06/22- resident had an area on left breast with irritation and a topical cream treated was initiated. The record lacked documentation of the effectiveness of the medication. 06/08/22 - R4 complained of pain in her feet and not able to sleep. The medical provider ordered gabapentin for her foot pain. The record lacked follow up on the effectiveness of the medication. 06/14/22- the record indicated the resident had a fall but lacked follow up for possible residual effects from the fall. 07/22/22 - resident seen by medical provider and ordered a right hip x-ray. The record lacked any indication of why a hip w-ray was obtained. 08/22/22 - resident went to the hospital and returned on 08/24/22. The record lacked follow up on her condition post hospital return. 10/05/22 - had new orders for Hospice consult and the record lacked documentation of the resident declining condition or reason for Hospice consult. On 07/25/23 at 02:16 PM Administrative Licensed Nurse B reported the resident notes needed to include any changes in states, medication, or treatment changes, follow up on any changes and falls as well as notification of family and physician. Administrative Licensed Nurse B acknowledged that she knew she had not documented in the record as she should have and acknowledged the handwritten notes did not include times that she put the notes in the record.	S3261		

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Review of the "Documentation" policy dated 07/19/22 revealed the "Healthcare Coordinator" is responsible for accurate and timely documentation in the resident record. Documentation will be based upon personal observation, action and communication and will document pertinent information.

The administrator failed to ensure designated staff documented the date and time of all incidents, symptoms, and other indications of illness or injury, what was done, and the results of action taken for R4.

- Review of R5's medical record revealed she moved into the facility on 04/27/22 with diagnoses of dementia and hypertension.

R5's "Functional Capacity Screen" identified she needed physical assistance with all activities of daily living except was independent with eating. She had impaired cognition, could not manage her medications or medical treatments, and had a risk for falls.

On 07/25/23 AT 09:42 AM Administrative Licensed Nurse B reported the "Negotiated Service Agreement" and the "Health Care Service Plan" (NSA/HCSP) are one document.

R5's NSA/HCSP included direction for staff to assist with activities of daily living, to administer and order her medications and that she used a wheelchair and received physical therapy and occupational therapy services.

Surveyor requested closed records for R5 for review. The records provided included the

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following nursing resident notes.
The record lacked resident notes prior to 05/07/22 and she moved into the facility on 04/27/22. The resident notes were all handwritten and all of the documented notes failed to include the time staff documented the concerns.
05/07/22 - The resident had a fall out of her wheelchair and went to the emergency room for evaluation. The record lacked further follow up on the resident's condition directly after the fall and return from the emergency room.
05/23/23- the resident had increased anxiety and the medical provider increased her Effexor (antidepressant) and a change in the time she received her Xanax (antianxiety). The record lacked follow up as to the effectiveness of the medication changes.
06/25/22- the resident started a new medication, Abilify (antipsychotic) for concerns with her mood and tearfulness. The record lacked follow up on the effectiveness or any adverse effects of the Abilify.
The last documentation in the record was dated 11/23/22 and the resident was discharged to another facility on 02/28/23. The record lacked documentation of the resident's status upon discharge from the facility.

On 07/26/23 at 10:28 AM Administrative Licensed Nurse B provided another folder of the resident's closed record and said it was all she could find. The folder provided by Administrative Licensed Nurse B did not include additional resident notes for review.

On 07/25/23 at 02:16 PM Administrative Licensed Nurse B reported the resident notes

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needed to include any changes in states, medication, or treatment changes, follow up on any changes and falls as well as notification of family and physician. Administrative Licensed Nurse B acknowledged that she knew she had not documented in the record as she should have and acknowledged the handwritten notes did not include times that she put the notes in the record.

Review of the "Documentation" policy dated 07/19/22 revealed the "Healthcare Coordinator" is responsible for accurate and timely documentation in the resident record. Documentation will be based upon personal observation, action and communication and will document pertinent information.

The administrator failed to ensure designated staff documented the date and time of all incidents, symptoms, and other indications of illness or injury, what was done, and the results of action taken for R5.

- Review of R6's medical record revealed he moved into the facility on 06/15/22 with diagnosis of Alzheimer's disease.

R6's most current "Functional Capacity Screen" dated 06/09/23 identified the resident needed physical assistance with bathing, dressing, toileting and supervision with transfers and mobility. He needed physical assistance with medication management and medical treatments, had impaired cognition and communication abilities, and was at risk for falls.

On 07/25/23 AT 09:42 AM Administrative

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S3261	Continued From page 35 Licensed Nurse B reported the "Negotiated Service Agreement" and the "Health Care Service Plan" (NSA/HCSP) are one document. R6's most current "Negotiated Service Agreement/Health Care Service Plan" initiated on 06/09/23 identified qualified staff provided physical assist with showers twice a week and Hospice provided those showers, was provided minimal assistance with dressing and was independent at times with toileting but staff needed to cue and prompt residents. Certified medication aides and Licensed Nurses administered medications and treatments - staff prompted and cued resident related to his impaired cognition. R6's resident nursing notes included the following: The handwritten resident notes from 08/02/22 to 01/27/23 all lacked the time staff documented in the record. 08/03/22 - provider discontinued the resident's Abilify (antipsychotic) and his Metoprolol (antihypertensive). The record lacked follow up of effectiveness after the medications were discontinued. 08/10/22 started on Zyprexa (antipsychotic) for increased confusion and refusal of cares. The record lacked follow up as to the effectiveness of the medications. 08/19/22 the resident had a fall but the record lacked documentation of follow up post fall. 09/09/22 the resident complained of low back pain and went to the emergency room and admitted for hypertensive crisis. The record lacked follow up upon the residents return from the hospital.	S3261		

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S3261	Continued From page 36 04/20/23 - had a fall and went to hospital with complaints of hip pain and returned on 04/26/22. The record lacked follow up documentation on the resident's status post hospital return and why resident was admitted to the hospital. On 07/25/23 at 02:16 PM Administrative Licensed Nurse B reported the resident notes needed to include any changes in states, medication, or treatment changes, follow up on any changes and falls as well as notification of family and physician. Administrative Licensed Nurse B acknowledged that she knew she had not documented in the record as she should have and acknowledged the handwritten notes did not include times that she put the notes in the record. Review of the "Documentation" policy dated 07/19/22 revealed the "Healthcare Coordinator" is responsible for accurate and timely documentation in the resident record. Documentation will be based upon personal observation, action and communication and will document pertinent information. The administrator failed to ensure designated staff documented the date and time of all incidents, symptoms, and other indications of illness or injury, what was done, and the results of action taken for R6.	S3261		
S3295 SS=F	26-41-206 (c) Dietary Services Menus (c) Menus. A dietetic services supervisor or licensed dietitian or, in any assisted living facility or residential health care facility with fewer than 11 residents, designated facility staff shall plan	S3295		

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S3295	Continued From page 37 menus in advance and in accordance with the dietary guidelines adopted by referencein K.A.R. 26-39-105. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(c) The facility reported a census of 57 residents. Based on observation, interview and record review the administrator failed to ensure designated dietary staff planned menus in advance and in accordance with the dietary guidelines adopted by reference in KAR 26-39-105. Findings included: - On 07/25/23 at 11:40 AM surveyor looked for the posting of the weekly menu and it was not where it was supposed to be. Surveyor asked 3 residents sitting at a table what was for lunch, and they reported they did not know until they come and ask us what we want to eat. Dietary staff went to a different table and asked the resident if they wanted a Rueben sandwich or tacos. On 07/24/23 at 11:59 AM Administrative staff A reported the menu includes two entrees and they can also order off the anytime available menu. He reported the menu rotates weekly and it is put out each week and posted in front of the dining room. He then stated the menus were pulled last	S3295		

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S3295	Continued From page 38 week but should be posted on the cards on the table each day for what they can choose. Administrative staff A stated the menus were pulled because "they were not appropriately served." On 07/25/23 at 12:24 PM Dietary staff H confirmed they did not have a menu to go by for what to prepare each day. He stated they look in the freezer and fridge and use what is available. He stated he tried to have a protein, starch and a vegetable and then some type of desert. The administrator failed to ensure designated dietary staff planned menus in advance and in accordance with the dietary guidelines adopted by reference in KAR 26-39-105.	S3295		
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 and regulations.	S3298		

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S3298	Continued From page 39 This REQUIREMENT is not met as evidenced by: KAR 26-41-206(d) The facility reported a census of 57 residents. Based on record review and interview, the administrator failed to ensure staff prepared and served food at the proper temperature. Findings included: - During initial tour on 07/24/23 at 10:05 AM Dietary Staff D reported the prior Chef did not complete food temperature logs and he just got one yesterday and will be getting started with documenting food temperature to ensure they are cooked to the proper temperature and served at the proper temperature. Review of the "Safe Food Handling" policy dated 03/18/14 revealed that food must be served at appropriate temperatures. Hot foods should be served at the following temperatures to ensure that they arrive at the table hot: Vegetables, potatoes, hot soups and beverages between 180 and 190 degrees Fahrenheit (F), Meats, casseroles, or creamed dishes 165 degrees F or above and chilled foods and beverages should be 40 degrees F or less. The administrator failed to ensure dietary staff monitored food cooking and serving temperatures to ensure it was prepared and served at the proper temperature.	S3298		

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S3299	Continued From page 40	S3299		
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 57 residents. Based on observation and interview the facility failed to store all food under safe and sanitary conditions. Findings included: - Observations on 07/24/23 at 09:52 AM the following observations of the walk-in refrigerator: Pan of macaroni and cheese three/fourths empty without a date on it or a label, a box with a bag of sausage patties in fridge that did not include the date the sausage was put into the refrigerator and the bag was not sealed, a steam pan covered with aluminum foil with a bag of some type of liquid in it that was not labeled or dated, and a container of orange Jell-O covered with saran wrap but not dated. The walk-in freezer revealed the following: A box of food on the floor of the freezer, open bags of crab cakes, chicken tenders, and green beans that were not sealed.	S3299		

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S3299	Continued From page 41 On 07/24/23 at 10:04 AM dietary staff D acknowledged all foods that were put in the walk-in refrigerator should have included the date put in the refrigerator and a label of what the food is. He also acknowledged the open bags in the freezer should have been closed and not open to risk freezer burn. Review of the "Focus on Food Safety" guidelines reveal foods that are prepared on-site, potentially hazardous foods, ready-to-eat foods and foods held for more than 24 hours should be date marked with the date by which food is to be consumed or discarded. The administrator failed to ensure designated staff stored foods in manner to ensure they were discarded when appropriate, labeled with food item, and sealed after being opened.	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: (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	S3305		

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S3305	Continued From page 42 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 57 residents. Based on observations and interview the administrator 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: - During kitchen observations on 07/25/23 at 11:44 AM revealed male and female staff in the	S3305		

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food prep area, cooking and fixing plates who did not have on any type of hair cover or beard cover to help protect from getting hair in resident's food.

On 07/25/23 at 11:44 AM an unidentified dietary cook prepared Ruben sandwiches touching the meat, cheese, bread and kraut with her gloved hands. She them heated it on the grill and would take her gloved hands and get a handful of tater tots and a handful of the salad to put on the plate. She continued to prepare the plates without changing her gloves for the first 15 minutes of observation. During the observations there were multiple staff who served the plates wearing gloves who grabbed tater tots and/or lettuce and put them on the plates. The servers did not change their gloves after delivering the plates, touching the tables and the back of resident chairs or residents themselves.

Dietary staff J had prepared a plate with a sandwich and tater tots, put it in the microwave for 10 seconds, did not check the food temperature and then took it out to the dining room and served it to a resident. While she was in the dining room she touched the table, the back of the resident's chair and then returned to the kitchen. She then cut a Reuben sandwich in half touching both halves and grabbed a handful of tater tots with the same gloved hands that she touched a resident's dining room chair and the table with. Dietary staff J then prepared a plate with tacos using her hands to pick up the shell and put lettuce on the plate all the time without changing her gloves and washing her hands.

On 07/25/23 at 11:48 AM Dietary Staff K had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089045	A. BUILDING: _____ B. WING _____	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGEND AT CAPITAL RIDGE	1931 SW ARVONIA PLACE TOPEKA, KS 66615

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3305	Continued From page 44	S3305		

been going in and out of the kitchen passing out plates and had not changed gloves. Dietary Staff K came into the kitchen, got a plate with a sandwich on it but did not have any tater tots. Dietary staff K got a handful of tater tots from the steam table, put them on the plate and proceeded to take them to a resident. During the meal service time there were multiple dietary staff who grabbed handfuls of the tater tots or lettuce and put them on resident plates without changing gloves.

On 07/25/23 at 11:50 AM dietary staff J acknowledged staff were supposed to be changing their gloves between serving each plate but haven't been doing it.

On 07/25/23 Dietary Consultant H stated she comes to the facility quarterly and there were a lot of dietary issues at that time but thought with a new manager things would get better. She stated the facility had approved menus in the past and did not know what happened to them as they should have menus from the corporate office. Dietary Consultant H stated staff were to wear hair coverings and should not be using their hands to plate tater tots and salad.

Review of the policies provided from the facility related to dining services, "Meal Planning", identified staff will follow necessary infection control precautions for food service.

Review of the Kansas Food Code 2022 from the Kansas Department of Agriculture revealed the following:
"... Food employees shall wear hair restraints such as hats, hair coverings or nets, beard

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S3305	Continued From page 45 restraints...and worn to effectively keep their hair from contacting exposed food..." "... Food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment." " Gloves... if used, single-use gloves shall be used for only one task ... and discarded when damaged or soiled, or when interruptions occur in the operation." The administrator failed to ensure dietary staff served foods using techniques to ensure the prevention of the spread of infections by the failure of staff to wear hair restraints in the food prep area and failure to properly use gloves.	S3305		