STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185250	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Manor	1100 Grandview Drive Flatwoods, KY 41139

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32635 Based on observation, interview, record review, review of the manufacturer's guidelines, review of a journal article, and review of the facility's policy, the facility failed to provide the services to prevent possible complications of enteral feeding including but not limited to diarrhea, vomiting, and dehydration, for 1 of 3 residents investigated for tube feeding care, sampled Resident (R) 83. Observations on [DATE] at 11:30 AM and 1:30 PM, revealed R83's tube feeding was hung and spiked, with the tubing primed. However, the facility's staff failed to document the time the tube feeding was hung. The findings include: Review of the facility's policy titled, Tube Feedings, not dated, revealed the tube feeding formula could hang for 24 to 48 hours, depending on the manufacturer's recommendation. Review of the formula company's recommendation guidelines, dated ,d+[DATE], revealed, for hang time, the referenced journal article was Enteral Nutrition Practice Recommendations Task Force, Enteral Nutrition Practice Recommendations, dated 2009, Journal of Parental Enteral Nutrition 2009; 33:,d+[DATE]. The article stated the open system should be changed every 24 hours. Review of the journal article Safety of Enteral Nutrition Practices: Overcoming the Contamination Challenges, Indian J Crit Care Med, 2020 Aug; 24(8):,d+[DATE], revealed most closed containers were discarded after 24 hours due to current manufacturer recommendations to change enteral feeding sets every 24 hours and to spike each closed container only once. Per the article, besides the feed, even the feeding delivery sets could be a source of contamination. Hence, they also needed to be replaced every 24 hours. Review of R83's Admission Record revealed the facility admitted the resident on [DATE] with diagnoses of diabetes mellitus type 2, cachexia, and depression. Review of R83's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 12 out of 15, which indicated R83 had moderate cognitive impairment. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R83's Physician's Orders, revealed an order with a date/start date of [DATE]. The order stated to administer, every night from 8:00 PM to 6:00 AM, enteral nutrition via pump of diabetic source AC 1.2 at 39 milliliters per hour (ml/hr) per the resident's percutaneous endoscopic gastrostomy (PEG) tube continuously, (10 hours nightly). Observation on [DATE] at 11:30 AM and 1:23 PM revealed R83 had a closed system tube feeding diabetic source 1.2 spiked and primed at the bed side. The tube feeding label was dated for [DATE] with start time of 8:00 PM and end time of 6:00 AM. However, the observation revealed the time the tube feeding was hung was not documented on the label. In an interview with R83's spouse on [DATE] at 1:30 PM, he stated the tube feeding ran at night. In an interview with Licensed Practical Nurse (LPN) 4 at [DATE] on 11:45 AM, she stated the tube feeding was thrown away after the run time, and the tube feeding was labeled and dated with the start time. She stated the tube feeding bottle was not spiked or primed until hung. She stated the tube feeding bottle should not be spiked or the tube feeding hung or primed until ready for use. She stated, with tube feeding, there was a potential for bacteria to enter the system; therefore, the tube feeding could only hang for 24 hours. In an interview with LPN2 on [DATE] at 8:30 AM, she stated the tube feeding was hung when the time started. She stated the tube feeding was hung for 48 hours. She stated, if the tube feeding was hung early, it could become cross contaminated, and the tube feeding in the set could dry in the tube. In an interview with LPN1, who was also the F Unit Coordinator, on [DATE] at 8:36 AM, she stated R83's tube feeding was scheduled for 10 hours. She stated the tube feeding was hung right before the beginning time, according to the physician's orders. She stated the nurses could not hang it early because they could forget to turn it on at the start time. She also stated, if hung early, the tube feeding in the tube would crust or dry and become unsanitary, and it should be thrown away. She stated R83's tube feeding should not have been left hanging, but thrown away. She stated the formula could become spoiled if allowed to hang so long prior to usage. In an interview with Registered Nurse (RN) Infection Preventionist (IP) Assistant Director of Nursing (ADON) 1 on [DATE] at 2:44 PM, she stated the tube feeding only hung for 24 hours. She stated, once the tube feeding was spiked, the closed system became an open system, and the clock started the 24 hour count down. She stated, if the tube feeding was left hanging greater than 24 hours, it could become cross contaminated with medications and potentially with bacteria. She stated, once the time had expired, the tube feeding and tubing should be removed and discarded. In an interview with LPN6 on [DATE] at 10:21 AM, she stated the tube feeding should be hung when it was due to start, following the physician's orders. She stated after 24 hours the nurse should discard the tube feeding. She stated, if it was changed in the middle of the night or the tube feeding ran out, the nurse could hang another to use again for that night. She stated, on [DATE], it had not been 24 hours. She stated she did not remember the time she changed the tube feeding. She stated R83's order changed from continuous tube feeding to continuous for 10 hours. In an interview with RN1 on [DATE] at 10:48 AM, she stated the tube feeding was hung at the start time. She stated the tube feeding was discarded at the end time and could not be reused for the next start time due to cross contamination. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with RN2 on [DATE] at 10:49 AM, she stated if R83's tube feeding did not run out prior to the stop time, the tube feeding should be taken down and thrown away. She stated the tube feeding could not be left for the next start time because it could become spoiled. In an interview with the Registered Nurse (RN) Director of Nursing (DON) on [DATE] at 9:26 AM, she stated when the tube feeding was hung at the start time, the tube was still capped at the end time, and did not hang greater then 24 hours, bacteria proliferation was not an issue. In an interview with the Administrator on [DATE] at 12:18 PM, he stated his expectation was the tube feeding hang for the scheduled time and not to spike ahead of time. He stated the tube feeding should be taken down when the time was completed.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 52554 Based on observation, interview, and review of the facility's current Spring/Summer cycle extension menus, the facility failed to ensure the puree diets were followed as determined by observations of the dinner tray line on 04/29/2025 and the lunch tray line on 04/30/2025 for 2 of 2 residents sampled for puree diets, Resident (R) 3 and R5. The findings include: 1. Review of the puree extension dinner menu for Tuesday, 04/29/2025 (Tuesday, week 1 dinner) revealed puree chicken salad croissant, tomato juice, puree cottage cheese, puree crackers, and puree fruit plate would be served. However, observation of the dinner meal on 04/29/2025 at 4:45 PM revealed, for Resident (R) 3 and R5, who received puree diets, the facility failed to provide a vegetable portion (tomato juice), bread portion (croissant), puree crackers and puree fruit plate, (or appropriate alternate items) per the puree diet extension. 2. Review of the puree extension lunch menu for Wednesday, 04/30/2025 (Wednesday, week 1 lunch) revealed puree cheesesteak, puree bun, puree tater tots, puree green beans, and puree fruit cocktail would be served. However, observation of a test tray on 04/30/2025 at 12:35 PM, which R3 and R5 received, revealed the puree lunch consisted of puree cheesesteak, puree bread, puree mashed potato, puree green beans, milk, iced tea, and regular Jello with no fruit pieces. The facility failed to provide puree tater tots and puree fruit cocktail. During an interview with morning [NAME] 1 on 05/01/2025 at 9:45 AM, the [NAME] stated, I puree all menu items separately: protein, starch, vegetable, bread, and dessert. When asked about Jello that was on the menu, the [NAME] stated, I would provide puree Jello or provide other puree if the extension calls for it. During an interview with morning Dietary Aide 1 on 05/01/2025 at 9:55 AM, she stated, I would puree separate items: meat, bread, mashed potatoes, green beans. When asked about puree dessert, she stated, Prep position takes care of dessert. During an interview with Dietary Aide 2 on 05/01/2025 at 10:00 AM, she stated, I puree whatever dessert is on the menu. When asked about Jello for puree diets, she stated, Plain Jello is provided without fruit. When asked about how she knew what to provide for a puree diet, the Prep Aide stated, I follow the diet sheets. During an interview with the Foodservice Director on 05/01/2025 at 10:10 AM, when asked about the correct diet for puree, she stated, Residents should not have received Jello; the pureed fruit was missed. Puree should include a separate protein, starch, vegetable, bread, and dessert. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Registered Dietitian (RD) on 05/01/2025 at 10:35 AM, she stated Menus are provided from an outside source, and the dietitian is responsible for nutrition adequacy. During an interview with the Executive Director on 05/02/2025 at 12:35 PM, he stated he had no involvement with cycle menus, and the . dietitian follows the recipe book. When asked about menus that failed to meet nutritional requirements, he stated, We are to follow the extension or to provide an equivalent.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 32635 Based on observation, interview, and review of a food safety article, the facility failed to serve food in a sanitary manner as determined by observation of the lunch service on 04/29/2025 and 04/30/2025 when the Dietary staff touched the clear plastic square bowls inside the rims with bare fingers as they turned the bowls over for service. This had the potential to affect all 84 current residents. The findings include: Review of the State Safe Food handling article Server Tips, Hands Off, dated 2025, https://www.statefoodsafety.com/Resources/Resources/server-tip-hands-off#:~:text=More%20importantly%20than%20the%20money,will%20be%20used%20by%20guests, revealed bare hand contact on dishes and utensils was an issue because bare hands spread germs. Observation on 04/29/2025 at 11:30 AM of the resident lunch tray line revealed the cook picked up and held the acrylic four ounce serving bowls with fingers touching the underside of the last bowl in the stack with her bare hand and fingers. . Observation on 04/30/2025 at 11:30 AM of the resident lunch tray line revealed Dietary Aide 2 picked up and held the acrylic four ounce serving bowls with fingers touching the underside of the last bowl with her bare hand and underneath the top two bowls. In an interview with the Dietary Manager on 05/01/2025 at 10:10 AM, she stated staff should handle the plastic clear square bowls by the bottoms and not put fingers over the rims because there was an infection control concern. In an interview with [NAME] 1 on 05/01/2025 at 9:30 AM, she stated she pulled the clear plastic square bowls off the shelf and turned them over by placing her hand on the bottom and turning over with her other hand. She stated it was not correct to touch the inside of the bowl with fingers to prevent the spread of germs from the fingers. In an interview with Dietary Aide 2 on 05/01/2025 at 9:45 AM, she stated it was correct not to touch the inside of the plate and the clear plastic square bowls to prevent the bacteria from fingers to cross contaminate. In an interview with the Registered Nurse (RN) Director of Nursing (DON) on 05/02/2025 at 9:37 AM, she stated she expected staff to prevent cross contamination by not putting fingers into the top of the bowl. She stated if a dish was contaminated by bare fingers or hands, it should be removed from the tray line. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Administrator on 05/02/2025 at 12:12 PM, he stated his expectation was for staff to handle dishware in a sanitary manner and to perform hand washing prior to handling clean dishware.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 32635 Based on observation, interview, and review of the facility's policies, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Observation on 04/29/2025 revealed Dietary Aide 1 coughed multiple times over the residents' trays on the lunch tray line for the D Unit cart. Dietary Aide 1 coughed into her elbow. However, she did not step back from the tray line, sanitize, or wash her hands. The deficient practice had the potential to affect all residents on the D Unit, with a census of 20. The findings include: Review of the facility's policy titled, Personal Hygiene and Health Reporting, dated 2019, revealed the food and nutrition services employees would be trained on appropriate personal hygiene and health reporting. Review of the facility's policy titled, Hand Washing, dated 2019, revealed employees would wash hands as frequently as needed throughout the day using proper hand washing procedures. Per the policy, hands should be washed after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking. Observation during the D Unit lunch tray line on 04/29/2025 at 11:30 AM to 11:55 AM, revealed Dietary Aide 1 was coughing into her elbow on the tray line and did not step away or wash/sanitize her hands. In an interview with Dietary Aide 1 on 05/01/2025 at 4:22 PM, she stated she had allergies. She stated she was taught to couch into her arm at the elbow (she demonstrated by coughing into her upper arm). She stated, on 04/30/2025, she went to an urgent treatment center for testing, and it was verified she just had allergies. She stated she was trained by the Dietary Manager to cough into her elbow and upper arm. In an interview with the Dietary Manager on 05/02/2025 at 9:12 AM, she stated Dietary Aide 1 should have stepped away from the line and covered her cough into the arm. She stated, if a staff member, such as Dietary Aide 1, continued to cough, they should be removed from the line. In an interview with the Registered Nurse (RN) Infection Preventionist (IP) Assistant Director of Nursing (ADON) 1 on 05/01/2025 at 2:44 PM, she stated staff was to cough into the elbow, using cough etiquette. She stated Dietary Aide 1 should have sanitized her hands between coughs. She stated if Dietary Aide 1 choked, she should step away from the line, take a drink of water, and sanitize hands. She stated if Dietary Aide 1 continued to cough, she needed to step away and wear a mask. She stated she expected Dietary Aide 1 to report to her on the day she felt sick at work. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Registered Nurse (RN) Director of Nursing (DON) on 05/02/2025 at 9:34 AM, she stated her expectation was to discard the tray and get another one. She stated Dietary Aide 1 should have taken the day off, wore a mask, or gone to the medical doctor. In an interview with the Administrator on 05/02/2025 at 11:54 AM, he stated coughing on the tray line posed a risk for contamination. He stated Dietary Aide 1 should have let another staff member take over her position on the tray line. He stated if Dietary staff felt sick, they should step away, have other staff take over their position, and report to the IP Nurse.