STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185285	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Breckinridge Memorial Nursing Facility	1011 Old Highway 60 Hardinsburg, KY 40143

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and policy review, the facility failed to prepare and serve food under sanitary conditions to prevent the potential for contamination during meal service. These failures had the potential to affect 18 of 18 residents who received meals from the dietary department.Review of the facility policy, Nutritional Services Infection Prevention and Control, revised 08/29/2022, revealed food handlers were required to perform hand hygiene prior to contact with or preparation of food items and beverages. Further review revealed employees were required to have hair covered with a hair net and beards and mustaches were to be kept close-cropped; however, the policy did not specify the use of beard guards/beard restraints.Review of the facility policy titled, Hand Hygiene, revealed the policy identified examples of when to perform hand hygiene, including before donning (putting on) personal protective equipment (PPE), after doffing (removing) PPE, and after touching a contaminated area and before moving to a clean area.Review of the facility policy titled, Food Temperatures, revised 07/2019, revealed temperatures were to be taken using a clean, calibrated thermometer.On 03/04/2026 at 9:01 AM, the surveyor met with the Dietary Manager (DM) in the kitchen and observed the DM in the kitchen without a beard restraint.On 03/04/2026 at 11:26 AM, the surveyor entered the kitchen to observe the meal tray line, and the DM was again observed in the kitchen without a beard restraint.During tray line service on 03/04/2026, multiple breaks in sanitary technique were observed. At 11:45 AM, Dietary Aide (DA) 3 donned gloves, adjusted the wall A/C remote control, and was prompted by the DM to change gloves. DA3 changed gloves but did not perform hand hygiene prior to donning the new gloves.Continued observations revealed at 11:47 AM, DA2 left the tray line to retrieve a ladle elsewhere in the kitchen and returned to the tray line without performing hand hygiene and without changing gloves. At 11:50 AM, DA2 left the tray line to retrieve mashed potatoes from the oven and returned without performing hand hygiene and without changing gloves. At 11:52 AM, DA1 left the tray line to retrieve an item from the warmer located outside the kitchen in the bistro area and returned without performing hand hygiene and without changing gloves.Further observations revealed at 12:01 PM, DA1 was observed standing with gloved hands held at the waist and resting against clothing.Other observations revealed improper handling and storage of the food thermometer during tray line service. At 11:57 AM, DA2 wiped a food thermometer with an alcohol wipe; however, DA2 then closed the thermometer with a gloved hand, and the gloved hand contacted the probe area. At 12:00 PM, DA2 used the same thermometer to take the temperature of a bowl of mashed potatoes. At 12:02 PM, DA1 wiped the thermometer after use but left it open on top of a temperature log binder with the probe in contact with the binder. At 12:05 PM, DA2 picked up the thermometer and used it to take the temperature of pureed chicken without re-wiping/sanitizing the probe. At 12:07 PM, DA2 cleaned the thermometer and set it down, open on an oven mitt, with the probe in contact with the mitt. At 12:09 PM, DA2 used the thermometer to take the temperature of pureed green beans without re-wiping/sanitizing the probe.During interview on 03/05/2026 at 9:36 AM, DA1 stated that if gloved hands touched a non-food item (including clothes), the required next step was to remove gloves, wash hands, and don new gloves, and stated that if gloved hands rested on clothing, the food could become contaminated, and residents could get sick.DA1 further stated the thermometer should be placed back (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	in the holding tray and should be closed between temperature checks.During interview on 03/05/2026 at 9:28 AM, DA2 stated that after leaving the tray line, staff should wash hands and change gloves and acknowledged failing to do so could spread bacteria/disease and make someone sick.During interview on 03/05/2026 at 9:45 AM, DA3 stated that if staff touched a non-food item while gloved, gloves should be removed and replaced, and handwashing would be expected because germs could contaminate gloves and make residents sick.During interview on 03/05/2026 at 2:24 PM, the DM stated that if staff had to leave the tray line, they should deglove, wash hands, and reglove, and stated failing to do so could result in cross contamination, exposure to an allergen, and exposure of pathogens to food.The DM stated thermometers should be sanitized with alcohol prep pads prior to use and after assessing temperatures of every individual item and stated the thermometer should be closed and placed in a container that held the prep pads between uses.The DM acknowledged that when supervising the tray line, the DM should have been wearing a beard guard.During interview on 03/05/2026 at 3:00 PM, the Assistant Director of Nursing (ADON) stated staff should wear hair and beard restraints in the food prep area and that when changing gloves, staff should wash hands between glove changes to prevent contamination of gloves and food, and stated that laying a thermometer probe on a binder or oven mitt was not sanitary practice.Neither the Director of Nursing nor the Administrator were available for interview.