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S 000	INITIAL COMMENTS The following citations represent the findings of the resurvey and complaints #156628, #152551, #147961, #146665, and #132051 for the above named facility conducted on 10/19/2020, 10/20/2020, 10/21/2020, 10/22/2020, 10/23/2020 and 10/26/2020.	S 000		
S3155 SS=G	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 36 residents. The sample included 3 residents and 1 focused review. Based on observation, interview and record review the administrator/operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for 1 (#179) of 4 sampled residents in accordance with the functional capacity screening and the negotiated service agreement regarding repeated development of a pressure ulcer (localized damage to the skin and/or underlying tissue which usually occurred over a bony prominence as a result of long term	S3155		

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

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pressure, or pressure in combination with shearing or friction). Resident #179, who was identified as at risk for skin breakdown, repeatedly developed pressure ulcers due to a failure to ensure a licensed nurse developed interventions to address the resident's risk for skin impairment, and implemented additional interventions after the development of pressure ulcers to promote healing and reduce the risk for further pressure ulcer development. On 04/13/2020 resident #179 developed a stage 2 pressure ulcer (skin breaks open, wears away or forms an ulcer with the appearance of an abrasion, blister or shallow crater) on the coccyx, on or about 08/08/2020 the resident developed a stage 2 ulcer on the left buttock which was identified as caused by pressure from the urinary catheter tubing and on 10/20/2020 was noted with a reoccurrence of a stage 2 pressure ulcer on the left buttock.

Findings Included:

- Record review for resident #179 revealed an admission date of 02/24/2020 with diagnosis of major depressive disorder, urinary tract infection, essential hypertension, heart failure, hemi paresis following cerebral infarction (left side deficit), bipolar disorder, constipation, retention of urine and altered mental status.

The admission functional capacity screen/negotiated service agreement dated 02/24/2020 completed by licensed nurse B identified the resident with deficits in memory recall and decision-making. She required physical assistance with bathing, dressing, toileting, transfers and medication/treatment management. She needed a wheelchair assistive device for mobility. The FCS/NSA indicated she had total

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bladder incontinence, was at risk for skin alteration, needed preventative measures and skin monitoring.
Review of addendums to the FCS/NSA dated 03/17/2020, 04/13/2020, and 07/04/2020 revealed none were related to any skin alterations.
The document titled, "Negotiated Service Agreement" which licensed nurses A, C, and D identified as the health care service plan (HCSP) dated 02/24/2020 included a problem related to skin alteration with a goal for the resident to remain free of any new or worsening open areas. The HCSP directed staff to help the resident drink fluids in order to stay hydrated, the nurse needed to complete a Braden scale (an assessment of pressure ulcer risk) upon admission, every 6 months and with each significant change.

The 02/24/2020 HCSP directed staff the resident had incontinence, please ensure her skin is kept clean and dry throughout the day/night. Staff should look over the resident's skin every time staff gave a bath or provided care and to let the nurse know of any new issues so they can be taken care of right away. The HCSP directed staff to let the medical care provider know right away if the resident's skin area looks worse. The section for continence directed staff the resident had incontinent episodes, staff should check every 2 hours and offer her assistance. She wore incontinent products and needed assistance with changing.

The HCSP section for bathing directed staff the resident preferred showers in morning twice weekly and hospice would also provide bed baths twice weekly (total of 4 bathing times a week). The section for ADLS indicated the resident needed staff assistance as follows: bed mobility

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with 2 staff and getting in/out of bed. Skin inspection-when assisting with ADLs observe skin for redness, open areas, scratches, cuts, tears, bruises/discoloration and report any changes to the nurse.

The HCSP lacked information related to the standard of care for changing positions at least every 2 hours or any pressure relieving devices in the wheelchair or bed for this resident identified at risk for pressure ulcer development.

Review of the electronic record revealed a Braden scale assessment dated 02/24/2020 which identified the resident with a moderate risk.

Due to the national pandemic around 03/16/2020 the facility needed to stop outside providers from coming into the facility. The HCSP lacked a revision to reflect the resident would not receive the 2 visits a week from Hospice for bathing or monitoring of the resident's skin.

Review of the interdisciplinary progress notes (IDPN) in the electronic record between 02/24/2020 thru 07/03/2020 revealed an entry by licensed nurse E on 04/13/2020 at 9:59 AM which identified an open area on the resident's coccyx measuring 0.5 centimeters (cm) by 0.5 cm. The note indicated the hospice nurse obtained orders for cleansing the wound and to cover it with Calmoseptine 4 times a day PRN (as needed). The next entry was dated 04/21/2020 at 10:08 AM indicating the open area measured 0.3 cm by 0.3 cm and staff continued with the Calmoseptine treatment. The IDPNs between 04/21/2020 and 08/01/2020 lacked any further mention of the resident's open areas on the coccyx.

The HCSP lacked an update regarding the actual

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skin alteration, treatment plan or other interventions related to pressure reduction, turning/repositioning or nutritional needs to promote healing and prevent further skin breakdown.

Review of the medication/treatment administration record for April 2020 and May 2020 revealed an entry to apply Calmoseptine to coccyx every 6 hours as needed. Neither record had any staff initials on any days to indicate the Calmoseptine treatment was administered.

The interdisciplinary progress note (IDPN) dated 08/01/2020 at 11:54 PM revealed at approximately 7:50 PM the resident had a fall while attempting a self-transfer which resulted in a right hip fracture as per mobile X-ray results. Licensed nurse H recorded the following as a plan of care for the resident: "current plan until otherwise noted: Bedrest, utilize PRN morphine prior to repositioning. Staff has been shown proper log roll technique and will be doing slight reposition changes q {every} 2 hours for prevention of skin breakdown". The IDPN dated 08/02/2020 at 4:14 PM indicated the medical care provider determined the resident was not a candidate for surgery due to the resident's overall condition. He recommended pain management and comfort measures. Licensed nurse H received orders for an alternating air mattress and indwelling urinary catheter for the resident.

The significant change functional capacity screen/negotiated service agreement (FCS/NSA) completed by licensed nurse A dated 08/03/2020 identified the resident with deficits in short-term memory and memory recall. The resident lacked the ability to perform activities of daily living (ADLs) for bathing, dressing, toileting, transfers

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and walk/mobility. She lacked the ability to manage her own medications or treatments and under wound/skin treatments she was identified in need of preventative measures and skin monitoring.
The document titled, "Negotiated Service Agreement" which licensed nurses A, C, and D identified as the health care service plan (HCSP) dated 08/03/2020 included special items to reduce pressure and prevent pressure sores. These items included a pressure reducing mattress overlay and heel protectors, completion of a Braden Scale assessment every six months and with significant change to identify skin risk. The HCSP continued to direct staff to look over the resident's skin with every bath and provision of cares and to let the nurse know if there were any new issues. The HCSP directed staff to provide physical assistance with a full sponge bath weekly. The resident was on bed rest until further notice, needed skin inspection when assisting with ADLs and directed staff to observer for any redness, open areas, scratches, cuts, tears, bruises/discolorations and report to the nurse. The HCSP directed staff the resident needed an abduction wedge pillow in place at all times, was at risk for dehydration and staff were to encourage fluids.

The 08/03/2020 HCSP lacked directions related to the standard of care for at least every 2 hours repositioning to reduce the risk for pressure ulcer development.

The Braden scale assessment dated 08/03/2020 identified the resident at moderate risk.

Review of medical care provider F's visit note dated 08/07/2020 indicated the resident had no rash or lesion noted. A note dated 09/02/2020

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included the resident had several small coin size areas of redness (lacked a location) which appear to be nearly healed. She had some red, raw areas to her buttock in 2 places with no active blisters observed. The note further indicated the resident had multiple areas in the groin where the catheter pressed against the skin and buttock in various stages of healing with no active blisters. Medical care provider F recorded reminding staff to make sure the resident was turned every 2 hours. Staff stated initially they were but family at the bedside stated the resident was not turned very often. Medical care provider F recorded explanation to staff of skin breakdown due to the pressure and ordered to continue application of Neosporin and to cover open areas.

Review of the medication/treatment administration record (MAR/TAR) for August 2020, September 2020 and October 2020 revealed an entry to apply Calmoseptine to coccyx every 6 hours as needed with no staff initials to indicate the Calmoseptine treatment was administered. The MAR/TAR lacked the above medical care provider's order for Neosporin and to cover open areas.

Review of resident's electronic record for repositioning every 2 hours in August 2020 revealed the night shift staff charted each night on the 14th thru the 19th, then the 22nd, 23rd, 24th, 26th, 28th and 29th. The repositioning record for September 2020 revealed the night shift charted on the 2nd, 5th thru the 8th, 10th, 11th, 12th, 14th, 17th thru the 20th, 23rd thru the 26th, 28th and 29th. The October 2020 record revealed night shift staff charted the 2nd, thru the 4th, 6th thru the 10th, 13th thru the 16th, and the 20th. All other shifts and days of the month had no staff initials to indicate the resident received

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repositioning every 2 hours as needed and ordered by the medical care provider.

Review of the resident bath charting revealed the following for August 2020: staff initial as performed on the 1st, 15th, 26th, and 29th. The September 2020 record had only 1 bath charted. The October 2020 record had only 1 bath charted. Interview on 10/21/2020 at 2:03 PM with licensed nurses A and C confirmed the above record for staff performance of bathing the resident and indicated the blank places on the record were the days staff should have provided the resident a bed bath.

Review of Hospice notes revealed the following (notes have no actual date of occurrence or nurse signature of who provided care and education to facility staff; transmission date to facility are all dated 08/18/2020 at 12:57 PM); first undated note "new blister noted to right outer and posterior thigh. Possible due to plastic of mattress overlay with no sheets on bed, made bed and reviewed with staff to monitor prevention of blisters. Keep skin clean and dry, reposition and report changes". The second note included dressing changes 3 times a week and indicated hospice nurse provided education to facility staff on monitoring the dressing and prevention of skin issues. The 3rd note indicated the hospice nurse educated facility staff on the blisters, causes and treatment.

On 10/08/2020 a confidential report to the state agency included undated pictures of the resident's skin. Observation of the pictures revealed the following: 8 circular dark red/brown skin alterations on the back side of the resident's right thigh. Most were half dollar in size and 1 was about the size of a tennis ball. The areas had

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S3155	Continued From page 8 some skin sloughing, some that looked crusty and some had a darker pink coloration in the center. The left leg had 7 places of skin alteration from quarter sized to tennis ball sized with dark red/brown coloration, sloughing or crusty skin and some dark pink skin. The left lateral side hip area had 3 places of skin alteration (2 were quarter sized and 1 pencil lead sized). The areas were in various stages of healing. There was a white square of medical type cloth adhesive tape just below these areas and the picture lacked the ability to visualize anything underneath. The picture of the buttocks revealed across the left upper buttock was a skin alteration presenting as a line which slightly curved approximately 5 inches in length and about 0.5 inches wide with 1 area of open, very dark red and raw skin, 2 smaller open areas with dark pink coloration and some sloughing/crusty skin (the width and appearance resembled the size of the catheter tubing). The coccyx area had some sloughing skin build up and skin color changes from previous pressure ulcer. The resident also had a partially healing area on her left cheekbone and the picture showed the oxygen tubing lined up with this area of skin alteration and a probable cause. The resident's feet had non-skid socks without any pressure relieving device or elevation, so they rested directly on the mattress. Another picture included the low loss air mattress overlay folded and placed on the couch in the resident's room, the reporter gave the approximate date of 08/08/2020 as date of pictures. Review of the interdisciplinary progress notes (IDPN) between 08/01/2020 and 10/19/2020 (last entry was 10/07/2020 at 12:08 PM) revealed an entry identified as a late entry dated 08/08/2020 at 11:49 AM - resident developed 4 blisters of unknown origin to the left extremity. Hospice	S3155		

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nurse assessed the area. The note indicated orders were received for clindamycin (an antibiotic used for skin infections) and may apply Neosporin to sites and cover with non-adhesive dressing. The note indicated the medication administration record was updated. The August 2020 medication/treatment administration record included the clindamycin order but lacked the order for the Neosporin and non-adhesive dressing. None of the other IDPN included any further information about the resident's skin condition.

Observation on 10/19/2020 at 4:10 PM revealed the resident rested in bed with her eyes closed, covered with a sheet and the room lights were off. Her heels appeared to be directly on the mattress with no outline of a leg elevation pillow/device and no outline of pressure relieving protectors on her feet. On her left cheek bone, she had a reddened area the size of a quarter.

Observation on 10/20/2020 at 12:07 PM during cares provided by licensed nurse C and hospice nurse G with the room lights on revealed the reddened area to the resident's left cheek also had a small area of open skin with sloughing and scaling. She had darker discolored areas of skin to the back of the left calf and top of the left arm. A reddened open area noted on the left upper buttock which per hospice nurse G estimated as 3 centimeters (cm) by 3 cm in size. The hospice nurse said the area was worse, she provided peri-care and applied Calmoseptine ointment on the area. Observation of both heels revealed slightly darker pink skin on the left heel. The resident rested directed on the blue mattress with no abduction pillow in place or anywhere visualized in the room. She had no heel protectors on or anywhere visualized in the room.

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Hospice nurse G indicated a flat pillow in the bedside chair was under the resident's lower legs when she started her care. The low loss air mattress remained folded and on the couch in the resident's room.

Observation on 10/20/2020 at 12:07 PM revealed on the wall next to the resident's bed was a regular sized piece of notebook type paper for staff to record the date and position change and a place for staff to sign. The instructions were to "visualize Q (every) 1 (hour)" and "Turn Q2" with a symbol for hour. Interview with licensed nurse C at the time of observation revealed the sheet was placed per the family request for staff to sign and document the care provided (The times to turn/reposition resident were: 1:00 AM, 3:00 AM, 5:00 AM, 7:00 AM, 9:00 AM, 11:00 AM, 1:00 PM, 3:00 PM, 5:00 PM, 7:00 PM. 9:00 PM, and 11:00 PM), She reported an expectation for staff to complete this documentation and she indicated she did not review the sheet for completion. The sheet revealed the following: on 09/27/2020 a line drawn through the 1:00 AM and 3:00 AM times, no initial on the 5:00 PM time, the letter R is in the position box, the 9:00 PM and 11:00 PM times and positions were blank. On 09/30/2020 the only 2 times marked are the 3:00 AM and 5:00 AM all other times were blank. On 10/01/2020 the only times charted were 3:00 PM, 5:00 PM, 7:00 PM and 9:00 PM, all other times were blank. On 10/02/2020 the only times charted were 3:00 PM, 5:00 PM, 7:00 PM, 9:00 PM, and 11:00 PM. On 10/03/2020 the 1:00 PM to 9:00 PM times were blank. On 10/04/2020 the 5:00 PM and 11:00 PM times were blank. On 10/05/2020 all times were blank except 3:00 PM, 5:00 PM, and 7:00 PM, this is the last entry on the page.

Interview on 10/20/2020 at 12:20 PM with

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Hospice nurse G and licensed nurse C confirmed the following pressure relieving devices were not in place; abduction pillow, heel protectors and the low loss air mattress. Hospice nurse G indicated the mattress in place was a gel mattress. Both nurses were unable to confirm the date when the mattress changed from low loss air to the gel mattress, the location of the abduction pillow or the heel protectors. Hospice nurse G confirmed hospice did not provide certified nurse aides for baths currently due to the COVID-19 virus.

Interview on 10/21/2020 at 12:51 PM with licensed nurse C revealed she tried to make skin inspections at the time of the hospice nurse visit. She reported there was no scheduled time frame for skin inspections. She confirmed she was unable to provide specific dates for any of her inspections of the resident's skin since she began employment on 08/28/2020. She confirmed she failed to make an entry in the resident's record when she made the skin observation and the record lacked any evidence of the skin condition after the entry on 08/08/2020 through the last entry dated 10/07/2020. She indicated she had a meeting with 1 of the resident's family members on approximately 09/04/2020 or 09/11/2020 and visualized the pictures listed above which identified major skin alterations for the resident. She reported she evaluated the resident's skin after the meeting and confirmed the record lacked this information. She reported the last time she viewed the resident's skin was on 10/16/2020 and said the coccyx wound was closed "last week". She confirmed the record lacked documentation to verify skin integrity at the time of her evaluation on 10/16/2020. She confirmed other than the documentation in the IDPNs on 04/13/2020, 04/21/2020 and 08/08/2020 the resident's record lacked information regarding the

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resident's prior skin issues and current skin issues.

Interview on 10/21/2020 at 12:00 PM with certified medication aide's (CMA) J and K revealed the following: CMA J started employment on 08/21/2020 and she confirmed resident #179 had blisters present on the backs of her thighs. CMA K started employment on 08/30/2020 and she confirmed blisters present on the back of resident #179's thighs.

Review of the undated facility policy for wound assessment prevention and treatment revealed the following: on admission resident's total skin will be assessed and documented on the resident admission. The Braden pressure risk assessment will be completed at that time and weekly for the first 4 weeks. All residents will have pressure reducing devices placed on their bed and wheelchair upon admission. If the resident requires assistance with reposition, he/she will be repositioned at least every 2 hours.

The administrator/operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for this resident in accordance with the functional capacity screening and the negotiated service agreement regarding repeated development of a pressure ulcer. On 04/13/2020 the resident developed a stage 2 pressure ulcer on the coccyx, on or about 08/08/2020 the resident developed a stage 2 ulcer on the left buttock which was identified as caused by pressure from the urinary catheter tubing and on 10/20/2020 the resident was noted with a reoccurrence of a stage 2 pressure ulcer on the left buttock.

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	N087042	A. BUILDING: _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF WICHITA	12221 W MAPLE ST WICHITA, KS 67235

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S3211	Continued From page 13	S3211		
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. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (g)(3) The facility reported a census of 36 residents. Based on observation, staff interview and record review the administrator/operator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on over the counter (OTC) medications and failed to write the name on both the original manufacturer's package of OTC medications and the container, bottle, or tube which could be removed from the original package. This deficient practice affected residents #112, #321, #410, #516, #728, and #830. Findings included: - On 10/19//2020 administrator/operator M	S3211		

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provided a resident roster which identified the facility managed medications for all 36 residents.

Observation during facility tour on 10/19/2020 at 4:16 PM revealed the following: certified medication aide (CMA) N opened the medication cart for the A and B hall, an opened box of refresh eye drops lacked a resident first and last name on the bottle or box. An unopened box of refresh eye drops lacked a resident's first and last name. CMA N and licensed nurse A confirmed the over the counter medication (OTC) lacked a resident first and last name. An opened bottle of acidophillis had a name in sharpie marker which had rubbed off and could not be read. Licensed nurse A confirmed at the time of observation the bottle of acidophillis belonged to resident #321 and the name could not be read on the bottle.

Observation during facility tour on 10/19/2020 at 4:27 PM revealed the following: certified medication aide (CMA) N opened the medication cart for the C and D hall, a box of gas x chew tabs only had the first name of resident #410, an opened box of stool softener 100 tabs had the first name and last initial for resident #516. The following bottles lacked any resident first and last names: allergy relief bottle loratadine, probiotic CD, 65mg iron tablets, open bottle of stool softener, and calcium 600mg. A bottle of D3 vitamins had an unreadable name on the side of the bottle and the lid had the first name of resident #516. A bottle of multivitamin for adult's eye health on the lid, had the first name of resident #728.

Observation during the tour of the memory care unit on 10/19/2020 at 4:45 PM revealed the following: certified medication aide (CMA) O carrying a clear plastic bag of medications. CMA

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S3211	Continued From page 15 O stated she "was just cleaning out the med cart for meds residents don't take any more". Review of medications removed from the medication cart revealed the following: opened bottles of diabetic tussin, melatonin, athlete's foot cream, and clotrimazole with the first name only for resident #830. The following lacked any resident first and last name: tube of nystatin cream, tube of calmoseptine, 3 tubes of medi honey, container of triad hydorphilic wound dressing. At 4:55 PM medication cart opened by CMA O revealed the following: for resident #830 a box of dry eye relief was labeled with resident first and last name, but not the tube. A bottle of daily vitamin had the first name of resident #830 on the lid and lacked the resident last name, an unopened bottle of daily vitamin had the first name only of resident #830. A bottle of melatonin had the first name only for resident #112. Interview with CMA O revealed the following: CMA O stated whoever gets the OTC medication writes the name on it. She stated she tried to when she gets them. Interview on 10/19/2020 at 5:00 PM with licensed nurse A confirmed the OTC medications were not labeled properly. The undated facility policy states 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 over the counter medication can be removed from the original package the licensed nurse or pharmacist shall place the full name of the resident on both the original manufacturer's medication package and the medication container. The administrator/operator failed to ensure a	S3211		

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S3211	Continued From page 16 licensed pharmacist or licensed nurse placed the full name of the resident on over the counter (OTC) medications and failed to write the name on both the original manufacturer's package of OTC and the container, bottle, or tube which could be removed from the original package. This deficient practice affected residents #112, #321, #410, #516, #728, and #830.	S3211		
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. This REQUIREMENT is not met as evidenced by: KAR 26-41-206 (d) The facility reported a census of 36 residents. The sample included 3 residents and 1 focused review. Based on observation, interview and	S3298		

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record review the administrator/operator failed to ensure staff served food at the proper temperature with the potential to affect all residents.

Findings included:

- Observation on 10/20/2020 at 11:25 AM revealed dietary staff L on duty.

Record review of food temperature log provided by dietary staff L for month of October 2020 revealed gaps in recording food temperatures prior to serving residents. Log lacked clear and precise information on food temperatures, and consistency in days/meals checked. On the left side of the page the meals were categorized: breakfast, lunch and supper. Under breakfast the following were listed: ground meat, pureed meat, hot cereal, eggs/bacon/sausage, toast/pancakes/french toast, pureed bread, milk, juice, and coffee. Under the lunch category the following were listed: soup, entree, entree, ground meat, pureed, meat, vegetable, vegetable, pureed vegetable, starch, pureed starch, cold entree, cold vegetable cold starch/dessert, and milk. Under the supper category the following were listed: soup, entree, entree, ground meat, vegetable, vegetable, pureed vegetable, starch, pureed starch, gravy/sauce, cold entree, cold vegetable, cold starch/dessert, and milk. Across the right side of the page were the days of the week, with the date above the corresponding day. On October 3rd, breakfast and lunch lacked any temperature documentation. The two temperatures recorded for the supper menu are one entree and one vegetable. On October 10th, the breakfast and lunch menus lacked documentation of temperatures, supper was the only meal documented as being tested. On

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S3298	Continued From page 18 October 11th, breakfast and lunch lacked any temperature documentation. On October 12th, supper lacked any temperature documentation. On October 15th and 16th, supper lacked any temperature documentation. On October 18th and 19th, supper lacked temperature documentation and it should be the expectation. Interview on 10/20/2020 at 11:28 AM with dietary staff L confirmed the lack of consistent documentation in the food temperature log. Interview on 10/22/2020 at 9:40 AM with administrator/operator M staff confirmed staff should be checking and recording food temperatures each meal. Review of the facility policy dated 04/06/2020 stated food temperatures of hot foods on room trays at the point of service are preferred to be at 120 degrees F or greater. The Kansas Department of Agriculture Focus on Food Safety 2017 recommended monitoring critical food temperatures, with a minimum of hot holding at 135 degrees and maximum cold holding at 41 degrees, during cooking, holding and serving to ensure food safety and decrease the risk of food borne illness. The administrator/operator failed to ensure staff served food at the proper temperature with the potential to affect all residents.	S3298		