STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE VILLAGE AT NORTHSIDE	1251 W 96TH ST, INDIANAPOLIS, , 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00362332 and IN00361242. Complaint IN00362332 - Substantiated. State deficiencies related to the allegations are cited at R29. Complaint IN00361242 - Unsubstantiated due to lack of evidence. Survey dates: September 15 and 16, 2021 Facility number: 003282 Residential Census: 80 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on September 21, 2021.	R 0000	The Following is the Plan of Correction for the Rittenhouse Village at Northside in regards to the Statement of Deficiencies dated September 16, 2021. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to delivery of quality health care services and will continue to make changes and improvement	

			to satisfy that objective.	
R 0029	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(d) (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on observation, interview and record review, the facility failed to ensure staff responded to a residents' emergency call pendent timely when activated for 1 of 5 residents reviewed for resident rights. (Resident B) Findings include: Resident B's clinical record was reviewed on 09/15/2021 at 2:41 p.m. Diagnosis included, but were not limited to, anxiety disorder, major depressive disorder and hypertension, chronic obstructive pulmonary disorder, asthma muscle weakness and respiratory failure. On 09/15/2021 at 12:31 p.m., Resident B was observed in her room to be sitting upright in her bed. A long pendent was hanging from her neck. During an interview, at this time, the resident stated the pendant was used to call for assistance when she needed it. She indicated it always took a "long time" for	R 0029	R029 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? . Resident B was checked on and needs were met . Call light policy was review with Resident B. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? . All residents have the potential to be affected. 3. What measures will be put into place or what	10/16/2021

	someone to come and "sometimes they never come". Resident B indicated it was extremely stressful for her when she activated the emergency call pendant and no one responded. She worried herself or someone else might need immediate medical attention and no one would be there to help. Resident B pushed the button on the pendant to activate the emergency call pendant to demonstrate how the pendant worked. A flashing red light on the pendant was seen which verified the pendant had been activated. According to the clock on the resident's wall, the time of the activation was 12:42 p.m. The resident continued to chat about her life and living at the facility. At 1:13 p.m., according to the resident's room clock, the emergency call pendant remained unanswered. The resident indicated the lack of response was "the norm". During an interview, on 09/15/2021 at 3:49 p.m., the Maintenance Supervisor (MS) indicated when a resident's pendant was activated, an alarm went to the computer, which in turn, transmits an alert to a pager carried by facility staff. The alert on the pager told the resident's name and what zone the resident was in at the facility so staff knew where to respond. At this time, the MS went to the Resident B's room and, with her		systemic changes the facility will make to ensure that the deficient practice does not recur: . All staff re-educated on resident rights and responding to call light policy on September 23, 2021. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. . Call light response time will be reviewed during daily stand up meeting and monitored during monthly QA meeting 5. By what date the systemic changes will be completed? October 16th, 2021.	

	permission, activated the emergency call pendant. When exiting the resident's room, an unidentified CNA was walking down the hall towards Resident B's room. The MS requested to see the pager she was carrying. The CNA removed a pager from her pocket and the alert on the pager indicated Resident B's pendant had been activated in her room. The CNA stated she was on her way to check on the resident. The CNA indicated to reset the pager and the pendant, she was required to physically touch the resident's pendant with a device she carried with her. A historical event log for emergency call pendants was requested and provided by the MS, on 09/15/2021 at 3:51 p.m. The event call log indicated the following: "9/15/21 12:37 PM ...(resident's name and location) ...Announced 9 times **Response Required but not received as of 1:22 p. 1:22 p This alert was never responded to - Alert Note Required but not entered -" "9/15/21 3:45 PM ...(resident's name and location) ...Reset pendent ..." A current facility policy, titled "Emergency Call Pendant," undated and received from the			

	Executive Director on 09/15/2021 at 1:33 p.m., indicated "POLICY: Residents will receive an emergency call pendant that can be worn at all times as a means to contact the in-house staff to assist them when the resident is unable to call via phone or other verbal or physical means. OBJECTIVE: Emergency call system is a pendant that transmits a call to an attendant to allow the resident to have immediate access to help in a urgent or emergency situation. PROCEDURE: Emergency call pendant are given to each resident on day of admission. Resident will be instructed on the steps to use the pendant and what he/she should expect as a standard response to usage. STEPS: Pendant is pressed by resident. The pendent (sic) will light and indicate to resident that it is transmitting a signal to the emergency call system. The staff member who acknowledges the pendent (sic) is responsible for responding to the resident in a timely manner. If you acknowledge the pendant but are unable to attend to the resident immediately, pleases use your walkie-talkie to verbally request assistance for the resident who pressed their pendant and you acknowledged.			

When staff has attended to the resident prior to leaving the staff musts restore the pendent (sic)...."

This State finding relates to Complaint IN00362332.

Based on observation, interview and record review, the facility failed to ensure staff responded to a residents' emergency call pendent timely when activated for 1 of 5 residents reviewed for resident rights. (Resident B)

Findings include:

Resident B's clinical record was reviewed on 09/15/2021 at 2:41 p.m. Diagnosis included, but were not limited to, anxiety disorder, major depressive disorder and hypertension, chronic obstructive pulmonary disorder, asthma muscle weakness and respiratory failure.

On 09/15/2021 at 12:31 p.m., Resident B was observed in her room to be sitting upright in her bed. A long pendent was hanging from her neck. During an interview, at this time, the resident stated the pendant was used to call for assistance when she needed it. She indicated it always took a "long time" for someone to come and "sometimes they never come". Resident B indicated it was extremely stressful for her when she activated the emergency

	call pendant and no one responded. She worried herself or someone else might need immediate medical attention and no one would be there to help. Resident B pushed the button on the pendant to activate the emergency call pendant to demonstrate how the pendant worked. A flashing red light on the pendant was seen which verified the pendant had been activated. According to the clock on the resident's wall, the time of the activation was 12:42 p.m. The resident continued to chat about her life and living at the facility. At 1:13 p.m., according to the resident's room clock, the emergency call pendant remained unanswered. The resident indicated the lack of response was "the norm". During an interview, on 09/15/2021 at 3:49 p.m., the Maintenance Supervisor (MS) indicated when a resident's pendant was activated, an alarm went to the computer, which in turn, transmits an alert to a pager carried by facility staff. The alert on the pager told the resident's name and what zone the resident was in at the facility so staff knew where to respond. At this time, the MS went to the Resident B's room and, with her permission, activated the emergency call pendant. When exiting the resident's room, an unidentified CNA was walking down the hall towards Resident			

	B's room. The MS requested to see the pager she was carrying. The CNA removed a pager from her pocket and the alert on the pager indicated Resident B's pendant had been activated in her room. The CNA stated she was on her way to check on the resident. The CNA indicated to reset the pager and the pendant, she was required to physically touch the resident's pendant with a device she carried with her. A historical event log for emergency call pendants was requested and provided by the MS, on 09/15/2021 at 3:51 p.m. The event call log indicated the following: "9/15/21 12:37 PM ...(resident's name and location) ...Announced 9 times **Response Required but not received as of 1:22 p. 1:22 p This alert was never responded to - Alert Note Required but not entered -" "9/15/21 3:45 PM ...(resident's name and location) ...Reset pendent ..." A current facility policy, titled "Emergency Call Pendant," undated and received from the Executive Director on 09/15/2021 at 1:33 p.m., indicated "POLICY: Residents will receive an emergency call pendant that can be worn at all			

	times as a means to contact the in-house staff to assist them when the resident is unable to call via phone or other verbal or physical means. OBJECTIVE: Emergency call system is a pendant that transmits a call to an attendant to allow the resident to have immediate access to help in a urgent or emergency situation. PROCEDURE: Emergency call pendant are given to each resident on day of admission. Resident will be instructed on the steps to use the pendant and what he/she should expect as a standard response to usage. STEPS: Pendant is pressed by resident. The pendent (sic) will light and indicate to resident that it is transmitting a signal to the emergency call system. The staff member who acknowledges the pendent (sic) is responsible for responding to the resident in a timely manner. If you acknowledge the pendant but are unable to attend to the resident immediately, pleases use your walkie-talkie to verbally request assistance for the resident who pressed their pendant and you acknowledged. When staff has attended to the resident prior to leaving the staff musts restore the pendent (sic)...."			

	This State finding relates to Complaint IN00362332.			
R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3) (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia.	R 0120	R120 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? . Qualified Medication Assistant 6 and CNA 7 will complete 3 hours of Dementia training by October 16th, 2021 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? . Audit has been completed of current team members and 3 hours of Dementia training will be completed for all who still need it. 3. What measures will be put into	10/16/2021

	(3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on interview and record review, the facility failed to ensure employees received an in-service in dementia care in the prescribed time frame for 2 of 5 employees reviewed for in-services (Qualified Medication Assistant 6 and CNA 7). Findings include: The employee records were reviewed on 09/16/2021 at 11:20 a.m. 1. Qualified Medication Assistant 6's record contained a document which indicated she received 3 hours of dementia training on 04/02/2019. 2. CNA 7's record contained a document which indicated she received 6 hours of dementia training on 03/04/2019.		place or what systemic changes the facility will make to ensure that the deficient practice does not recur: . Training schedule will be put in place at beginning of each year to ensure all required trainings are completed. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: . Audit tool has been created to monitor team member’s completion and will be reviewed monthly at QA. 5. By what date the systemic changes will be completed? October 16th, 2021.	

	During an interview, on 09/16/2021 at 2:18 p.m., the Executive Director indicated she was unable to provide any dementia training for 2020 for both staff members. Staff should receive dementia training annually and she was aware some staff were behind. During an interview, on 09/16/2021 at 4:39 p.m., the Executive Director indicated the facility followed the state guidelines for providing the required educational in-services. Based on interview and record review, the facility failed to ensure employees received an in-service in dementia care in the prescribed time frame for 2 of 5 employees reviewed for in-services (Qualified Medication Assistant 6 and CNA 7). Findings include: The employee records were reviewed on 09/16/2021 at 11:20 a.m. 1. Qualified Medication Assistant 6's record contained a document which indicated she received 3 hours of dementia training on 04/02/2019. 2. CNA 7's record contained a document which indicated she received 6 hours of dementia training on 03/04/2019.			

	During an interview, on 09/16/2021 at 2:18 p.m., the Executive Director indicated she was unable to provide any dementia training for 2020 for both staff members. Staff should receive dementia training annually and she was aware some staff were behind. During an interview, on 09/16/2021 at 4:39 p.m., the Executive Director indicated the facility followed the state guidelines for providing the required educational in-services.			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the	R 0217	R217 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? . Resident E and Resident F service plans will be signed by October 16, 2021	10/16/2021

	resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure service plans were signed by the resident or the resident's representative for 2 of 7 records reviewed for service plans (Resident E and F). Findings include: 1. The record for Resident E was reviewed on 09/15/2021 at 3:23 p.m. Diagnoses included, but were not limited to, hypertension, anxiety and end stage renal failure. The record for Resident E contained a service plan, dated		2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? . All residents have the potential to be affected. An audit was completed of all service plans for resident/responsible party signatures. Any service plans not in compliance were noted and resident/families notified to correct. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: . All Nurses will be re-educated on nurse Service Plans on September 23, 2021.	

	07/30/2021, it was not signed or dated by the resident or designee. 2. The record for Resident F was reviewed on 09/21/2021 at 3:41 p.m. Diagnoses included, but were not limited to, Diabetes Mellitus, hypertension and asthma. The record for Resident F contained a service plan, dated 07/05/2021, it was not signed or dated by the resident or designee. During an interview, on 09/16/2021 at 3:50 p.m., the Director of Nursing indicated all service plans should be signed and dated. A current policy, titled "Care Plan and Service Plan Guidelines for Care," dated 01/01/2010 and provided by the Executive Director on 09/16/2021 at 4:40 p.m., indicated "...2.3 The agreed upon service plan shall be signed and dated by the resident or designee...." Based on interview and record review, the facility failed to ensure service plans were signed by the resident or the resident's representative for 2 of 7 records reviewed for service plans (Resident E and F). Findings include:		4. How the corrective actions will be monitored to ensure the deficient practice will not recur . DHW or designee will report at weekly managers meeting updates of service plans awaiting signatures and follow up being taken and will be monitored during QA meeting monthly. 5. By what date the systemic changes will be completed? October 16, 2021.	

	1. The record for Resident E was reviewed on 09/15/2021 at 3:23 p.m. Diagnoses included, but were not limited to, hypertension, anxiety and end stage renal failure. The record for Resident E contained a service plan, dated 07/30/2021, it was not signed or dated by the resident or designee. 2. The record for Resident F was reviewed on 09/21/2021 at 3:41 p.m. Diagnoses included, but were not limited to, Diabetes Mellitus, hypertension and asthma. The record for Resident F contained a service plan, dated 07/05/2021, it was not signed or dated by the resident or designee. During an interview, on 09/16/2021 at 3:50 p.m., the Director of Nursing indicated all service plans should be signed and dated. A current policy, titled "Care Plan and Service Plan Guidelines for Care," dated 01/01/2010 and provided by the Executive Director on 09/16/2021 at 4:40 p.m., indicated "...2.3 The agreed upon service plan shall be signed and dated by the resident or designee...."			

R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure staff wore a face mask and had their hair restrained while preparing food and failed to discard expired items, cover the large meat slicer, clean the fryer area and floor beneath the fryer, to have the correct amount of disinfectant in the 3 compartment sink and in the water buckets, kept moisture from occurring in between stacked clean dishes and to pureed food following a recipe. This deficient practice had the potential to effect 80 out of 80 residents which received food from the kitchen. Findings include: 1. During a kitchen observation, on 09/15/2021 at 11:23 p.m., Dietary Server 1 was observed without a face mask, a hair net or a facial covering over his beard. He was standing next to the prep area which had 2 sheet	R 0273	R273 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Dietary Server 1 was re-educated on 9/15/2021 and immediately put on proper face mask, hair net and facial covering. 2. A. Cook 3 was re-educated on 9/16/2021 and immediately put on proper face mask and facial hair covering. B. Hot dogs, heavy whipping cream and butter milk in reach in refrigerator were discarded. C. Heavy whipping cream, buttermilk, pudding in walk in refrigerator were discarded.	10/16/2021

	pans of rolls uncovered. At that time, he indicated he should have had a hair net and face mask on. 2. During a tour of the kitchen, on 09/16/2021 at 10:34 a.m., with Cook 3 and the Maintenance Manager in attendance, the following were noted: a. Cook 3 was observed spooning pudding into individual dishes. His face mask was pulled below his chin and he did not have a hair net over his facial hair. He indicated, at that time, he thought if he were in a room by himself he did not have to wear a face mask and he should have had his facial hair covered. b. In the reach in refrigerator: Nine hot dogs were in a clear plastic bag with a date of 09/03 written on the front. One opened quart container of heavy whipping cream was half full with an expiration date of 09/04/2021. One opened quart container of buttermilk was half full with an expiration date of 09/05/2021. c. In the walk in refrigerator:		D. Large meat slicer was covered when not in use. E. fryer area was cleaned F. Ecolab came out on 9/16/2021 corrected the ppm level of the sanitizing water. G. dishes were rewashed and properly dried before being used H. Resident's is no longer on pureed diet and team members have been re-educated on pureeing 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? . All residents have the potential to be affected by the deficient practice. 3.	

	Two unopened quart containers of heavy whipping cream with expiration dates of 09/04/2021. Five unopened quart containers of buttermilk with expiration dates of 09/05/2021. Eight cups of pudding, not covered, with a thick layer of film on top of each dish, Cook 3 indicated, at that time, the puddings were from the previous days lunch and they should have been covered before placing in the refrigerator and all expired food items should have been discarded immediately. He also indicated he kept left over foods for 7 days and was unaware of what the facility policy said. d. The large meat slicer was observed without a cover. Cook 3 indicated large appliances, like the meat slicer, should be covered when not in use. e. The fryer area was dirty with a thick layer of brown/black grease all around it and under it. There was several old French fries on top of the caked grease beneath the fryer. Cook 3 indicated the area should be cleaned at least weekly but this did not always happen and there was not any way to clean the grease beneath the fryer and the fries and grease had been there for a long time. f. The three compartment sink		What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: . New Dietary Mangers hired, all dietary team members will be re-educated on sanitation and safe food handling standards, audit and monitoring tools to do used daily to ensure compliance 4. How the corrective actions will be monitored to ensure the deficient practice will not recur: . All audit tools will be review during monthly QA meeting 5. By what date the systemic changes will be completed? October 16, 2021	

was filled with wash, rinse and sanitizing water. The sanitizing water was tested for the right amount of sanitizer solution using litmus paper by the Maintenance Manager. It indicated the water contained 150 ppm (parts per million) of sanitizer, the Maintenance Manager, at that time, indicated the water should contain between 200 ppm and 400 ppm. The drainage line which delivered the sanitizer into the water had a visible air pocket in the tubing and he indicated this was why it was not delivering the correct amount of sanitizer. The sanitizing solution mixed with water kept in buckets used to clean the food prep surface areas were also tested and showed the same amount of sanitizer, 150 ppm.

g. Clean bowls were observed drying on a 3 wire shelf. The bowls were stacked in each other and were 3 or 4 bowls high. When the dishes were unstacked, there was moisture with small pools of water observed between the bowls. Cook 3 indicated, at that time, the bowls were clean and should have been placed in a single layer to air dry correctly.

h. On 09/16/2021 at 11:24 a.m., Cook 3 was observed pureeing corn and peas for a resident on memory care who was on a pureed diet. He indicated, at

that time, he had never used a recipe and was unsure the facility had any. He placed to large scoops of vegetables in the Robo Coup (appliance used to puree foods) and started the machine. When asked if he measured anything, he indicated he estimated the amount to be around 8 oz. After the vegetables were pureed, he added thickener, again he did not use any measuring utensil. When asked how he knew if the vegetables were the right consistency, he indicated "he had no idea" this was just the way he was shown how to do it so this was the way he did it.

A current policy, titled "Hair Nets," undated and provided by the Executive Director on 09/15/2021 at 3:00 p.m., indicated "...Staff will cover their hair/beard with a covering while preparing or serving food....The employee that is preparing/serving food will obtain a hair net/restraint and or beard restraint upon beginning their shift. Restraint will be worn at all times while preparing/serving food...."

A current policy, titled "Disposable Face Mask Usage," undated and provided by the Executive Director on 09/15/2021 at 3:00 p.m., indicated "...1. Disposable face mask will fit properly over the mouth and nose area....Face

masks will be worn for extended use as described by the CDC guidelines...."

A current policy, titled "Handling of Leftover Food," undated and provided by the Executive Director on 09/16/2021 at 3:00 p.m., indicated "...leftovers should be covered...refrigerated left overs should be used within 72 hours after opening...."

A current policy, titled "Cleaning Instructions: Food Slicer," undated and provided by the Executive Director on 09/16/2021 at 3:00 p.m., indicated "...17. Cover with plastic wrap between uses...."

A current policy, titled "Manual Washing of Dishes and Cookware," undated and provided by the Executive Director on 09/16/2021 at 3:00 p.m., indicated "...C. Sink three - fill sink with water...add the appropriate amount of detergent according to manufacturer's guidelines: c. Quaternary Ammonium (disinfectant solution added to the water) 200 ppm... 4. D. Drying - items will be inverted in a single layer and air dried...."

A current policy, titled "Nutrition Services Sanitation Guidelines and Terminology," undated and provided by the Executive Director on 09/16/2021 at 3:00 p.m., indicated "....8. Quaternary

Solutions: Disinfectants made with water and quaternary ammonium compounds that are suitable for cleaning and sanitizing hard surfaces...the final concentration of the solution is 200 ppm...."

A current policy, titled "Pureed Food Preparation," undated and provided by the Executive Director on 09/16/2021 at 3:00 p.m., indicated "...2. Standardized recipes will be used to produce pureed foods to maintain nutrient content...Commercial thickeners may also be used...Recipes will reflect the addition of these items...."

Based on observation, interview and record review, the facility failed to ensure staff wore a face mask and had their hair restrained while preparing food and failed to discard expired items, cover the large meat slicer, clean the fryer area and floor beneath the fryer, to have the correct amount of disinfectant in the 3 compartment sink and in the water buckets, kept moisture from occurring in between stacked clean dishes and to pureed food following a recipe. This deficient practice had the potential to effect 80 out of 80 residents which received food from the kitchen.

Findings include:

1. During a kitchen observation, on 09/15/2021 at 11:23 p.m., Dietary Server 1 was observed without a face mask, a hair net or a facial covering over his beard. He was standing next to the prep area which had 2 sheet pans of rolls uncovered. At that time, he indicated he should have had a hair net and face mask on.

2. During a tour of the kitchen, on 09/16/2021 at 10:34 a.m., with Cook 3 and the Maintenance Manager in attendance, the following were noted:

a. Cook 3 was observed spooning pudding into individual dishes. His face mask was pulled below his chin and he did not have a hair net over his facial hair. He indicated, at that time, he thought if he were in a room by himself he did not have to wear a face mask and he should have had his facial hair covered.

b. In the reach in refrigerator:

Nine hot dogs were in a clear plastic bag with a date of 09/03 written on the front.

One opened quart container of heavy whipping cream was half full with an expiration date of 09/04/2021.

One opened quart container of buttermilk was half full with an expiration date of 09/05/2021.

c. In the walk in refrigerator:

Two unopened quart containers of heavy whipping cream with expiration dates of 09/04/2021.

Five unopened quart containers of buttermilk with expiration dates of 09/05/2021.

Eight cups of pudding, not covered, with a thick layer of film on top of each dish, Cook 3 indicated, at that time, the puddings were from the previous days lunch and they should have been covered before placing in the refrigerator and all expired food items should have been discarded immediately. He also indicated he kept left over foods for 7 days and was unaware of what the facility policy said.

d. The large meat slicer was observed without a cover. Cook 3 indicated large appliances, like the meat slicer, should be covered when not in use.

e. The fryer area was dirty with a thick layer of brown/black grease all around it and under it. There was several old French fries on top of the caked grease beneath the fryer. Cook 3 indicated the area should be cleaned at least weekly but this did not always happen and

	there was not any way to clean the grease beneath the fryer and the fries and grease had been there for a long time. f. The three compartment sink was filled with wash, rinse and sanitizing water. The sanitizing water was tested for the right amount of sanitizer solution using litmus paper by the Maintenance Manager. It indicated the water contained 150 ppm (parts per million) of sanitizer, the Maintenance Manager, at that time, indicated the water should contain between 200 ppm and 400 ppm. The drainage line which delivered the sanitizer into the water had a visible air pocket in the tubing and he indicated this was why it was not delivering the correct amount of sanitizer. The sanitizing solution mixed with water kept in buckets used to clean the food prep surface areas were also tested and showed the same amount of sanitizer, 150 ppm.			

g. Clean bowls were observed drying on a 3 wire shelf. The bowls were stacked in each other and were 3 or 4 bowls high. When the dishes were unstacked, there was moisture with small pools of water observed between the bowls. Cook 3 indicated, at that time, the bowls were clean and should have been placed in a single layer to air dry correctly.

h. On 09/16/2021 at 11:24 a.m., Cook 3 was observed pureeing corn and peas for a resident on memory care who was on a pureed diet. He indicated, at that time, he had never used a recipe and was unsure the facility had any. He placed to large scoops of vegetables in the Robo Coup (appliance used to puree foods) and started the machine. When asked if he measured anything, he indicated he estimated the amount to be around 8 oz. After the vegetables were pureed, he added thickener, again he did not use any measuring utensil. When asked how he knew if the vegetables were the right consistency, he indicated "he had no idea" this was just the way he was shown how to do it so this was the way he did it.

A current policy, titled "Hair Nets," undated and provided by the Executive Director on 09/15/2021 at 3:00 p.m., indicated "...Staff will cover their

hair/beard with a covering while preparing or serving food....The employee that is preparing/serving food will obtain a hair net/restraint and or beard restraint upon beginning their shift. Restraint will be worn at all times while preparing/serving food...."

A current policy, titled "Disposable Face Mask Usage," undated and provided by the Executive Director on 09/15/2021 at 3:00 p.m., indicated "...1. Disposable face mask will fit properly over the mouth and nose area....Face masks will be worn for extended use as described by the CDC guidelines...."

A current policy, titled "Handling of Leftover Food," undated and provided by the Executive Director on 09/16/2021 at 3:00 p.m., indicated "...leftovers should be covered...refrigerated left overs should be used within 72 hours after opening...."

A current policy, titled "Cleaning Instructions: Food Slicer," undated and provided by the Executive Director on 09/16/2021 at 3:00 p.m., indicated "...17. Cover with plastic wrap between uses...."

A current policy, titled "Manual Washing of Dishes and Cookware," undated and provided by the Executive

Director on 09/16/2021 at 3:00 p.m., indicated "...C. Sink three - fill sink with water...add the appropriate amount of detergent according to manufacturer's guidelines: c. Quaternary Ammonium (disinfectant solution added to the water) 200 ppm... 4. D. Drying - items will be inverted in a single layer and air dried...."

A current policy, titled "Nutrition Services Sanitation Guidelines and Terminology," undated and provided by the Executive Director on 09/16/2021 at 3:00 p.m., indicated "....8. Quaternary Solutions: Disinfectants made with water and quaternary ammonium compounds that are suitable for cleaning and sanitizing hard surfaces...the final concentration of the solution is 200 ppm...."

A current policy, titled "Pureed Food Preparation," undated and provided by the Executive Director on 09/16/2021 at 3:00 p.m., indicated "...2. Standardized recipes will be used to produce pureed foods to maintain nutrient content...Commercial thickeners may also be used...Recipes will reflect the addition of these items...."

PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		