DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/22/2021
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK OF MUNCIE	STREET ADDRESS, CITY, STATE, ZIP CODE 2410 E MCGALLIARD RD, MUNCIE, , 47303		

(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. Survey dates: October 21 and 22, 2021 Facility number: 004428 Residential Census: 45 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 26, 2021.	R 0000	*Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.*	
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving	R 0273	**R 273 Food and Nutritional Serviced-deficiency**	11/21/2021

	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 sanitize equipment, and prepare and serve food in a manner that prevented possible contamination and/or cross contamination for 1 of 1 meal services observed (lunch 10/21/21). Findings include: During an 10/21/21, 10:09 a.m., interview, Cook 2 identified herself as the individual currently in charge of managing the dietary department. She indicated she was the only dietary staff member working that shift. She indicated the dietary department served meals to all residents in the facility. During a lunch meal observation on 10/21/21 from 12:04 p.m. to 12:30 p.m. the following concerns were identified: At 12:04 p.m., Cook 2 washed her hands and put on gloves. As Cook 2 was preparing to serve lunch, she dropped an oven mitt on the floor. She placed a second oven mitt on the floor on top of the dropped mitt. She		**1.** **What corrective action(s) will be accomplished for those residents found to** **have been affected by the deficient practice:** Cook 2 was re-educated by the Executive Director on 10/21/2021 on safe food handling practices, prevention of food contamination and cross contamination, and the proper procedure for sanitizing food thermometer. **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:**	

	used the top mitt to pick both mitts up from the floor and placed both mitts with the other mitts on the hood of the stove for future use. At 12:05 p.m., she began the process of meal service, with gloved hands she touched an ink pen, counter top, bowls, plates, the stove top, stove knobs, oven handles, spatula, ladle and knife. With the same contaminated gloves she picked up baked potatoes and cut slits in the top. At 12:12 p.m. the cook took the temperature of 3 food items. She took a food thermometer and tested the temperature of a baked potato. She then took a dry paper towel and wiped off the thermometer. She did not clean the thermometer with a sanitizing agent nor wash it with soap and water. With the same thermometer she had cleaned with a paper towel, she tested the chili. After testing the chili, she again wiped the thermometer with a dry paper towel. She did not clean or sanitize the thermometer. Using the thermometer she had wiped with a paper towel, she tested the tomato soup. At 12:16 p.m., the cook once again washed her hands and put on new clean gloves. These same gloves remained on her hand until the meal observation		An audit of the kitchen was done on 11/5/2021 by the Executive Director to ensure safe food handling practices are followed and food thermometers are being sanitized according to policy. No issues identified. **3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** Current staff will be re-educated by 11/21/2021 by the Executive Director on safe food handling practices, prevention of food contamination and cross contamination, and the proper procedure for sanitizing food thermometer. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The	

ended at 12:30 p.m. With her gloved hands, she touched a ladle, placed baked potatoes in the bowl for service, squeezed potatoes opened, filled a bowl with shredded cheese, picked up shredded cheese and topped potatoes, scooped lettuce from the edge of the plate, picked up salad dressing cups, opened the oven, stirred soup, adjusted oven knobs, and repeated this process approximately 10 times.

At 12:18 p.m., the cook then opened the refrigerator with the same gloved hands. She took a plate of peanut butter and jelly sandwiches from the refrigerator and placed them on the serving counter. She removed the covering from the sandwiches and picked up a sandwich with the same contaminated gloved hand, She placed that sandwich on a plate for services. She returned to placing potatoes, chili, cheese, tomatoes soup on plates using the same gloved hands.

At 12:20 p.m., the cook went to the cabinet. She opened the cabinet with her gloved hand and removed a container of peanut butter. She open a bag of bread with the same contaminated gloves. She removed two slices of bread with her gloved hands. She held the bread on the palm of her contaminated gloved hand. She spread peanut butter on the

Chef is responsible for sustained compliance. The Executive Director or designee will conduct observational audits of the kitchen during meal service 3 times per week for 4 weeks, then 2 times per week for 4 weeks, then weekly for 4 weeks to ensure safe food handling and kitchen sanitation practices and procedures are maintained. Results of the spot checks will be discussed in the monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going.

5 By what date the systemic changes will be completed

bread. She placed the peanut butter sandwich on a paper plate. She closed the peanut butter and placed it back in the cabinet with the same gloved hands. She then picked the peanut butter sandwich off the paper plate with her same contaminated gloved hands and carried it to the food service counter and placed it on a plate for service.

For the remainder of the meal observation, the cook returned to cutting potatoes, squeezing potatoes, string foods, picking up shredded cheese, pushing lettuce off the edge of the plate, picking up sandwiches, and picking up dressing cups all with the same contaminated gloved hands.

An undated, current, facility policy titled "Glove and Utensil Use", which was provided by the administrator in 10/22/21 at 9:00 a.m., indicated the following:

"Change disposable gloves as often as hand washing is required."

A 4/17/17, current, facility policy titled " Kitchen Sanitation, Equipment Maintenance and Safety", which was provided by the Administrator on 10/22/21 at 8:55 a.m., indicated the following:

"Equipment which comes in

contact with food must be washed and sanitized on a regular basis."

A 4/17/17, current, facility policy titled "Four Factor that Directly Cause Food to Become Unsafe", which was provided by the Administrator on 10/22/21 at 9:43 a.m., indicated the following:

"Cross Contamination - Cross contamination occurs when utensils, hands or other foods transfer microorganisms from one food or surface to the other."

Based on observation, interview, and record review, the facility failed to sanitize equipment, and prepare and serve food in a manner that prevented possible contamination and/or cross contamination for 1 of 1 meal services observed (lunch 10/21/21).

Findings include:

During an 10/21/21, 10:09 a.m., interview, Cook 2 identified herself as the individual currently in charge of managing the dietary department. She indicated she was the only dietary staff member working that shift. She indicated the dietary department served meals to all residents in the facility.

During a lunch meal observation on 10/21/21 from 12:04 p.m. to 12:30 p.m. the following concerns were identified:

At 12:04 p.m., Cook 2 washed her hands and put on gloves. As Cook 2 was preparing to serve lunch, she dropped an oven mitt on the floor. She placed a second oven mitt on the floor on top of the dropped mitt. She used the top mitt to pick both mitts up from the floor and placed both mitts with the other mitts on the hood of the stove for future use.

At 12:05 p.m., she began the process of meal service, with gloved hands she touched an ink pen, counter top, bowls, plates, the stove top, stove knobs, oven handles, spatula, ladle and knife. With the same contaminated gloves she picked up baked potatoes and cut slits in the top.

At 12:12 p.m. the cook took the temperature of 3 food items. She took a food thermometer and tested the temperature of a baked potato. She then took a dry paper towel and wiped off the thermometer. She did not clean the thermometer with a sanitizing agent nor wash it with soap and water. With the same thermometer she had cleaned with a paper towel, she tested the chili. After testing the chili, she again wiped the

	thermometer with a dry paper towel. She did not clean or sanitize the thermometer. Using the thermometer she had wiped with a paper towel, she tested the tomato soup. At 12:16 p.m., the cook once again washed her hands and put on new clean gloves. These same gloves remained on her hand until the meal observation ended at 12:30 p.m. With her gloved hands, she touched a ladle, placed baked potatoes in the bowl for service, squeezed potatoes opened, filled a bowl with shredded cheese, picked up shredded cheese and topped potatoes, scooped lettuce from the edge of the plate, picked up salad dressing cups, opened the oven, stirred soup, adjusted oven knobs, and repeated this process approximately 10 times. At 12:18 p.m., the cook then opened the refrigerator with the same gloved hands. She took a plate of peanut butter and jelly sandwiches from the refrigerator and placed them on the serving counter. She removed the covering from the sandwiches and picked up a sandwich with the same contaminated gloved hand, She placed that sandwich on a plate for services. She returned to placing potatoes, chili, cheese, tomatoes soup on plates using the same gloved hands.			

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For the remainder of the meal observation, the cook returned to cutting potatoes, squeezing potatoes, string foods, picking up shredded cheese, pushing lettuce off the edge of the plate, picking up sandwiches, and picking up dressing cups all with the same contaminated gloved hands.

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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