STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1019 SENIOR LIVING VERMILLION PLACE	449 MAIN ST, ANDERSON, , 46016

(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 Complaint IN00356074 and IN00355849. Complaint IN00355849 - Substantiated. State Residential Findings are cited at R0187 and R0178 Complaint IN00356074 - Substantiated. State Residential Findings are cited at R0268, R0269, R0273, R0274, R0326, R0328, R0088, and R0116 Survey dates: July 7, 8, & 9, 2021 Facility number: 011970 Residential Census: 28 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality reveiw completed on July 16, 2021.	R 0000	Preparation and/or execution of this Plan of Correction in general or any corrective action set forth herein, in particular, does not constitute an admission or agreement by Vermillion Place of the facts alleged or the conclusions set forth in the statement of deficiencies The Plan of Correction and the specific corrective actions are prepared and/or executed solely because of provisions of state laws. Vermillion Place desires this Plan	

			of Correction to be considered the facility's Allegation of Compliance. Compliance is effective August 31, 2021. This building respectfully requests consideration for paper compliance from this Plan of Correction. ALL 20 ATTACHMENTS WILL BE SENT BE FAX	
R 0088	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(c)(1-2)(d)(1-2) c) The licensee shall: (1) appoint an administrator with either a: (A) comprehensive care facility administrator license as required by IC 25-19-1-5(c); or (B) residential care facility administrator license as required by IC 25-19-1-5(d); and (2) delegate to that administrator the authority to organize and implement the day-to-day operations of the facility. (d) The licensee shall notify the director:	R 0088	1. The facility will continue to employee a Licensed Health Facility Administrator who over sees the daily operations of the facility. The current Licensed Health Facility Administrator was hired October 7, 2015. She has remained continuously employed in the position since that date. The only times she was unavailable were due to medical issues and has been on medical leave. She was available by phone while on medical leave. She was unavailable to work during the survey due to a recent outpatient surgery and physicians orders. All residents had the potential to be affected by the alleged deficient practice. 2.All residents had the potential to be affected by the alleged deficient practice.The facility will continue to employee a Licensed Health facility Administrator who over sees the	07/10/2021

	(1) within three (3) working days of a vacancy in the administrator's position; and (2) of the name and license number of the replacement administrator Based on observation, interview and record review, the facility failed to employee an lcensed Health Facilities Administrator who oversaw the daily operations of the facility. Finding Include: During the 3 days of the survey conducted on July 7, 8, and 9, 2021, the Licensed Health Facility Administrator was not present in the facility. Paperwork required for the survey process was completed by the Director. During a 7/7/21, 9:20 a.m., interview, the Director indicated she was to act as the replacement, or as a substitute to the Administrator in her absence. The Director indicated she herself was not a licensed Health Facilities Administrator. During a 7/9/21, 11:25 a.m. interview, the Director indicated the Administrator was last in the facility on 6/23/2021. She indicated the Administrator was in the facility 6/23/2021, 6/8/21, 6/1/21 and 5/24/21 (four times in a one month period). The Director indicated the		daily operations of the facility. Current Licensed Health Facility Administrator was hired October 7, 2015. She has remained continuously employed in the position since that date. The only times she was unavailable were due to medical issues and has been on medical leave. She was available by phone while on medical leave. She was unavailable to work during the survey due to a recent outpatient surgery and physicians orders. 3. A Licensed Health Facility Administrator will continue to be employed by this facility. If for any reason the Licensed Health Facility Administrator leaves their position, or if their is not a current Licensed Health Facilities Administrator employed the Indiana State Department of Health, Long Term Care Division will be notified by the Board of Directors. 4. The Board of Directors will monitor the position of the Licensed Health Facilities Administrator, to ensure one is employed. IDR I am requesting and IDR on this Tag. The reason for the IDR is: Christy Tompkins has been the Administrator at Vermillion Place since 10/7/2015. She was unavailable during the Annual Survey due to health issues. There is a possibility she may need to have extensive back and/or neck surgeries. A Dr. statement can be provided if necessary. The only time she has been unavailable to	

	Administrator did not come in the facility on a daily or even weekly basis, but was instead available by phone. She indicated this was the standard practice of the facility and had been for a lengthy period of time. During an interview on 7/9/21 at 11:35 a.m., QMA 6 indicated the Director oversaw the daily operations of the facility. She additionally indicated she had never seen or heard of a facility Administrator. During an interview on 7/9/21 at 11:36 a.m., Laundry Staff 16 indicated the Director oversaw the daily operations of the facility. She indicated she did not know of an Administrator. During an interview on 7/9/21 at 11:37 a.m., Laundry Staff 17 indicated the Director oversaw the daily operations of the facility and she was unaware of an Administrator. During an interview on 7/9/21 at 11:39 a.m., the Maintenance Supervisor indicated the Director's name and stated she was the Administrator. During an interview on 7/9/21 at 11:41 a.m., Dietary Aid 5 indicated the Assistant Director's name was the Administrator and oversaw the daily operations of the facility.		work is due to vacation, illness or other health issues, family illness, emergencies, scheduled days off or a death in the family. The Maintenance Supervisor is very hard of hearing and wears hearing aides, he may have misunderstood the Surveyors questions, as he knows the Administrator well. Dietary Aide #3 is well known by the Administrator. and he becomes very nervous when questioned about anything, he also has special needs. She was available by phone 24 hours a day. See attachments#1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16.	

	During an interview on 7/9/21 at 11:42 a.m., Dietary Aid 3 indicated there was an Administrator. He couldn't remember her name. He indicated he believed he had met her once in five years of employment. He additionally indicated he generally worked days. During a 7/9/21, 11:43 a.m., interview, Housekeeper 18 indicated there was and Administrator however she could not remember her name. She indicated she believed she had seen the Administrator maybe twice in her 3 months of employment. Lastly she indicated, the Director oversaw the daily operations of the facility. This residential tag relates to complaint IN00356074. Based on observation, interview and record review, the facility failed to employee an lcensed Health Facilities Administrator who oversaw the daily operations of the facility. Finding Include:			

	During the 3 days of the survey conducted on July 7, 8, and 9, 2021, the Licensed Health Facility Administrator was not present in the facility. Paperwork required for the survey process was completed by the Director. During a 7/7/21, 9:20 a.m., interview, the Director indicated she was to act as the replacement, or as a substitute to the Administrator in her absence. The Director indicated she herself was not a licensed Health Facilities Administrator. During a 7/9/21, 11:25 a.m. interview, the Director indicated the Administrator was last in the facility on 6/23/2021. She indicated the Administrator was in the facility 6/23/2021, 6/8/21, 6/1/21 and 5/24/21 (four times in a one month period). The Director indicated the Administrator did not come in the facility on a daily or even weekly basis, but was instead available by phone. She indicated this was the standard practice of the facility and had been for a lengthy period of time.			

During an interview on 7/9/21 at 11:35 a.m., QMA 6 indicated the Director oversaw the daily operations of the facility. She additionally indicated she had never seen or heard of a facility Administrator.

During an interview on 7/9/21 at 11:36 a.m., Laundry Staff 16 indicated the Director oversaw the daily operations of the facility. She indicated she did not know of an Administrator.

During an interview on 7/9/21 at 11:37 a.m., Laundry Staff 17 indicated the Director oversaw the daily operations of the facility and she was unaware of an Administrator.

During an interview on 7/9/21 at 11:39 a.m., the Maintenance Supervisor indicated the Director's name and stated she was the Administrator.

During an interview on 7/9/21 at 11:41 a.m., Dietary Aid 5 indicated the Assistant Director's name was the Administrator and oversaw the daily operations of the facility.

During an interview on 7/9/21 at 11:42 a.m., Dietary Aid 3 indicated there was an Administrator. He couldn't remember her name. He indicated he believed he had met her once in five years of employment. He additionally indicated he generally worked

	days. During a 7/9/21, 11:43 a.m., interview, Housekeeper 18 indicated there was and Administrator however she could not remember her name. She indicated she believed she had seen the Administrator maybe twice in her 3 months of employment. Lastly she indicated, the Director oversaw the daily operations of the facility. This residential tag relates to complaint IN00356074.			
R 0116	Personnel - Noncompliance 410 IAC 16.2-5-1.4(a) (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on interview and record review, the facility failed to ensure employee criminal history checks and reference checks were completed as part of pre-employment screening, and the facility did not hire an employee with a history of a felony conviction for 2 of 5 employee files reviewed for	R 0116	1. Facility has specific written procedures for the screening of prospective employees. All prospective employees will have reference checks done and criminal history checks done, either by mail or electronically, as part of the pre-employment screening. The Maintenance and grounds employee who was hired to work only on the grounds, not inside the facility, has been terminated. Employee QMA #6 has had her reference checks completed. 2. All residents had the potential to be affected by the alleged deficient practice.. Facility has specific written procedures for the screening of prospective employees. All prospective employees will have reference checks done and criminal history checks done, either by mail or electronically, as part of the pre-employment screening. The	08/26/2021

	screening prior to beginning working in the facility. (QMA 6 and Maintenance and Grounds Employee 8) Findings include: A 7/8/2021, employee records review indicated the following employees lacked reference checks and/or criminal history checks as follows: a. QMA 6, with a start date of 6/9/21 did not have completed reference checks in her employee record. b. Maintenance and Grounds Employee 8, with a start date of 3/12/20, did not have reference checks or a criminal history check in his employee record. During a 7/9/2021, 11:05 a.m., interview the Director indicated the facility did not have a criminal history check for Maintenance and Grounds Employee 8 nor reference checks for Maintenance and Grounds Employee 8 or QMA 6. She indicated Maintenance and Grounds Employee 8 had a felony conviction for battery, but was unaware that a felony battery conviction would prohibit the facility from hiring an individual. This residential tag relates to complaint IN00356074. Based on interview and record		Maintenance and grounds employee who was hired to work only on the grounds, not inside the facility, has been terminated. Employee QMA #6 has had her reference checks completed. 3. All prospective employees will have criminal history checks, done either by mail or electronically, and reference checks completed as part of their pre-employment screening. 4. The Director or their designee will review all prospective employees files to ensure that all prospective employees have criminal history checks and references completed prior to beginning work at the facility. If an issue occurs with either the criminal background checks or the reference checks the Administrator or her designeewill be informed to aid in correction.	

	review, the facility failed to ensure employee criminal history checks and reference checks were completed as part of pre-employment screening, and the facility did not hire an employee with a history of a felony conviction for 2 of 5 employee files reviewed for screening prior to beginning working in the facility. (QMA 6 and Maintenance and Grounds Employee 8) Findings include: A 7/8/2021, employee records review indicated the following employees lacked reference checks and/or criminal history checks as follows: a. QMA 6, with a start date of 6/9/21 did not have completed reference checks in her employee record. b. Maintenance and Grounds Employee 8, with a start date of 3/12/20, did not have reference checks or a criminal history check in his employee record. During a 7/9/2021, 11:05 a.m., interview the Director indicated the facility did not have a criminal history check for Maintenance and Grounds Employee 8 nor reference checks for Maintenance and Grounds Employee 8 or QMA 6. She indicated Maintenance and Grounds Employee 8 had a felony conviction for battery, but			

	was unaware that a felony battery conviction would prohibit the facility from hiring an individual. This residential tag relates to complaint IN00356074.			
R 0119	Personnel - Noncompliance 410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming	R 0119	1. All residents had the potential to be affected by the alleged deficient practice. The following employees have received their annual dementia training: a. Maintenance & Grounds Employee has been terminated. b. Housekeeper c. Maintenance Supervisor d. CNA 11 e. QMA 12. The following employees have documentation of a health screen: a. QMA 6, b. CNA 14, c. Dietary Aide 5 has been terminated. d. Maintenance & Grounds Employee 8 has been terminated. The following employees have documentation of receiving a tuberculin risk assessment screening: a. QMA 6, b. CNA 15, c. Dietary Aide 5 has been terminated, d. Maintenance & Grounds Employee 8 has been terminated. All new hires, prior to working independently shall be given an orientation to the facility by their supervisor(or their designee). Employees who have been employed for greater than 1 year will have 3 hours of annual dementia training. New employees will have documentation of a health screen upon hire. The Director has been informed of the requirements of a health screen upon hire. The	08/31/2021

	policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on observation and interview, the facility failed to ensure employees who had been employed for greater than 1 year had 3 hours of annual dementia training for 6 of 6 employees reviewed for annual dementia training (Maintenance and Grounds Employee 8, Housekeeper 9, Maintenance Supervisor, CNA 11, and QMA 12), newly hired employees had health screen completed for 4 of 5 employees reviewed (QMA 6, CNA 14, Dietary Aid 5, and Maintenance and Grounds Employee 8), and newly employed employees received tuberculin skin tests or completed TB risk assessments for 4 of 5 reviewed fro tuberculin		Director and the Assistant have been provided with the correct facility form to use. New employees will have documentation of a tuberculin risk assessment screening and/or a Mantoux (TB) skin test. 2. All residents had the potential to be affected by the alleged deficient practice. The following employees have received their annual dementia training: a. Maintenance & Grounds Employee has been terminated. b. Housekeeper c. Maintenance Supervisor d. CNA 11 e. QMA 12. The following employees have documentation of a health screen: a. QMA 6, b. CNA 14, c. Dietary Aide 5 has been terminated. d. Maintenance & Grounds Employee 8 has been terminated. The following employees have documentation of receiving a tuberculin risk assessment screening: a. QMA 6, b. CNA 15, c. Dietary Aide 5 has been terminated, d. Maintenance & Grounds Employee 8 has been terminated. All new hires, prior to working independently shall be given an orientation to the facility by their supervisor(or their designee). Employees who have been employed for greater than 1 year will have 3 hours of annual dementia training. New employees will have documentation of a health screen upon hire. New employees will have documentation of a tuberculin risk assessment screening and/or a Mantoux (TB) skin test.	

	screening (QMA 6, CNA 15, Dietary Aid 5, and Maintenance and Grounds Employee 8).(Maintenance and Grounds Employee 8, Housekeeper 9, Maintenance Supervisor, CNA 11, and QMA 12), Findings Include: A 7/8/2021, employee record review, indicated the following employees lacked documentation of annual dementia training in the 2020 to 2021 years. a. Maintenance and Grounds Employee 8, start date 3/11/20, b. Housekeeper 9, start date 4/25/02, c. Maintenance Supervisor, start date 4/2/18, d. CNA 11, start date 2/21/20, e. QMA 12, start date 6/26/08. During an interview on 7/9/21 at 11:45 a.m., the Assistant Director indicated the scheduled dementia training had been canceled when outside agencies could not come in to the facility to provide training and had yet to occur. She had scheduled the training for later in 2021. She had no 2020 to 2021 dementia training for employees. A 7/8/2021, employee record		3. All employees who have been employed greater than 1 year will have 3 hours of annual dementia training done. All newly hired employees will have documentation of a health screen upon hire. New employees will have documentation of a tuberculin risk assessment screening and/or a Mantoux (TB) skin test. 4.The Director, or their designee, will monitor the annual 3 hour dementia training for employees who have been employed over 1 year, pre-employment health screening and employee tuberculin risk assessment and/or a Mantoux (TB) skin test, monthly for 3 months, then every 3 months for 6 months. If issues occur than they cannot correct, they will notify the Administrator, or their designee, for assistance in correcting the issue.	

	review, indicated the following new employees lacked documentation of a health screen upon hire: a. QMA 6, start date 6/9/21, b. CNA 14, start date 4/21/21, c. Dietary Aid 5, start date 6/18/21, d. Maintenance and Grounds Employee 8, start date 3/11/20. During an interview on 7/9/21, 11: 30 a.m.. the Director indicated the facility had not completed health screens for newly hired employees and had not realized they were required. A 7/8/2021, employee record review, indicated the following new employees lacked documentation of a tuberculin risk assessment screening and/or a Mantoux (TB) skin test: a. QMA 6, start date 6/9/21, b. CNA 15, start date 5/28/21, c. Dietary Aid 5, start date 6/18/21, d. Maintenance and Grounds Employee 8, start date 3/11/20. During a 7/9/21, 11: 33 a.m.. interview, the Director indicated the facility had not completed Tuberculin Risk Assessments or Mantoux skin tests for newly			

hired employees.

Based on observation and interview, the facility failed to ensure employees who had been employed for greater than 1 year had 3 hours of annual dementia training for 6 of 6 employees reviewed for annual dementia training (Maintenance and Grounds Employee 8, Housekeeper 9, Maintenance Supervisor, CNA 11, and QMA 12), newly hired employees had health screen completed for 4 of 5 employees reviewed (QMA 6, CNA 14, Dietary Aid 5, and Maintenance and Grounds Employee 8), and newly employed employees received tuberculin skin tests or completed TB risk assessments for 4 of 5 reviewed fro tuberculin screening (QMA 6, CNA 15, Dietary Aid 5, and Maintenance and Grounds Employee 8).(Maintenance and Grounds Employee 8, Housekeeper 9, Maintenance Supervisor, CNA 11, and QMA 12),

Findings Include:

A 7/8/2021, employee record review, indicated the following employees lacked documentation of annual dementia training in the 2020 to 2021 years.

a. Maintenance and Grounds Employee 8, start date 3/11/20,

b. Housekeeper 9, start date

	4/25/02, c. Maintenance Supervisor, start date 4/2/18, d. CNA 11, start date 2/21/20, e. QMA 12, start date 6/26/08. During an interview on 7/9/21 at 11:45 a.m., the Assistant Director indicated the scheduled dementia training had been canceled when outside agencies could not come in to the facility to provide training and had yet to occur. She had scheduled the training for later in 2021. She had no 2020 to 2021 dementia training for employees. A 7/8/2021, employee record review, indicated the following new employees lacked documentation of a health screen upon hire: a. QMA 6, start date 6/9/21, b. CNA 14, start date 4/21/21, c. Dietary Aid 5, start date 6/18/21, d. Maintenance and Grounds Employee 8, start date 3/11/20.			

	During an interview on 7/9/21, 11: 30 a.m.. the Director indicated the facility had not completed health screens for newly hired employees and had not realized they were required. A 7/8/2021, employee record review, indicated the following new employees lacked documentation of a tuberculin risk assessment screening and/or a Mantoux (TB) skin test: a. QMA 6, start date 6/9/21, b. CNA 15, start date 5/28/21, c. Dietary Aid 5, start date 6/18/21, d. Maintenance and Grounds Employee 8, start date 3/11/20. During a 7/9/21, 11: 33 a.m.. interview, the Director indicated the facility had not completed Tuberculin Risk Assessments or Mantoux skin tests for newly hired employees.			
R 0178	Physical Plant Standards - Deficiency 410 IAC 16.2-5-1.6(b) (b) The facility shall have adequate plumbing, heating, and ventilating systems as governed by applicable rules of the fire prevention and building safety commission (675 IAC). Plumbing, heating, and ventilating systems shall be maintained in normal operating	R 0178	1.The facility will continue to ensure resident rooms are maintained at a comfortable temperature for all residents. Residents B & C rooms are maintained at a comfortable temperature. They both have working air conditioners. All residents rooms have working air conditioners and are maintained at a comfortable temperature. Any resident's whom room air	08/31/2021

	condition and utilized as necessary to provide comfortable temperatures in all areas. Based on observation, interview and record review, the facility failed to ensure resident rooms were maintained at a comfortable temperature for 2 of 3 residents whose room air conditioners had broken in June 2021. (Residents B and C). Findings include: 1. During a 7/7/21, 10:40 a.m. to 11:40 a.m., environmental tour with the Maintenance Supervisor, Resident C's room did not have a functioning air conditioner. There was no thermostat which monitored the rooms temperature nor any other method to monitoring room temperature. A hand held thermometer measured the room at 83 degrees Fahrenheit at this time. During a 7/7/21, 11:03 a.m., interview, Resident C indicated at this moment it was cool enough to sleep with a fan, but if it got any warmer he didn't know if he would be able to. 2. During an interview on 7/7/21 at 11:05 a.m., the Maintenance Supervisor indicated Resident B had not been concerned when his air conditioning went out about a month ago (June 2021) and indicated he didn't care if it was replaced. The Maintenance		conditioner stops working will be offered a temporary roomwith air conditioning while theirs is being replaced. A hand held thermometer will be purchased so we can ensure resident's rooms are maintained at a comfortable temperature if the air conditioning is not working correctly and the resident refuses to change rooms. 2. All residents have the potential to be affected. The facility will continue to ensure resident rooms are maintained at a comfortable temperature for all residents. All residents rooms have working air conditioners and are maintained at a comfortable temperature. Any resident's whom room air conditioner stops working will be offered a temporary roomwith air conditioning while theirs is being replaced. A hand held thermometer will be purchased so we can ensure resident's rooms are maintained at a comfortable temperature if the air conditioning is not working correctly and the resident refuses to change rooms. 3. The resident's room air conditioners are on the Maintenance Supervisor preventative maintenance program. The Maintenance Supervisor or their designee will monitor the residents room air conditioners per the facilities maintenance program. Any resident's whom room air conditioner stops working will be offered a temporary roomwith air conditioning while theirs is being replaced. 4.The Director, or their designee, will monitor the room air	

	Supervisor indicated the facility had not monitored Resident B's room temperature to ensure the temperature maintained at a safe level since the air conditioner stopped working nor had he followed up with the resident to ensure he remained comfortable. During an interview on 7/8/21 at 2:00 p.m., Resident B indicated her room air conditioner stopped working mid June. She indicated the facility said they would replace or repair it but it would take a few days. She indicated the facility did not offered her another room to temporarily stay in during the repair. Lastly she indicated, her room was uncomfortable and she had to leave the facility and stay with family a few days during the air conditioner replacement. Resident B's clinical record was reviewed on 7/8/21 at 10:15 a.m.. Resident B's record indicated she was out of the facility visiting her family on 6/12/21 and 6/13/21. During an interview on 7/8/2021 at 1: 45 p.m., the Director indicated the facility did not have a record of monitoring Resident Cs room temperature to ensure safety after his air conditioner went out nor did they offer Resident B a temporary room with air conditioning while her's was		conditioning Preventative Maintenance Program for completion every month for 6 months, then the Maintenance Supervisor, or their designee, will monitor the room air conditioning monthly during the preventative maintenance program. This is ongoing. If any problems are noted that cannot be corrected by the Director, they will notified the Administrator for their assistance in correcting the problem. See attachments #17, #18, #19.	

being replaced.

This residential tag relates to complaint IN00355849.

Based on observation, interview and record review, the facility failed to ensure resident rooms were maintained at a comfortable temperature for 2 of 3 residents whose room air conditioners had broken in June 2021. (Residents B and C).

Findings include:

1. During a 7/7/21, 10:40 a.m. to 11:40 a.m., environmental tour with the Maintenance Supervisor, Resident C's room did not have a functioning air conditioner. There was no thermostat which monitored the rooms temperature nor any other method to monitoring room temperature. A hand held thermometer measured the room at 83 degrees Fahrenheit at this time. During a 7/7/21, 11:03 a.m., interview, Resident C indicated at this moment it was cool enough to sleep with a fan, but if it got any warmer he didn't know if he would be able to.

2. During an interview on 7/7/21 at 11:05 a.m., the Maintenance Supervisor indicated Resident B had not been concerned when his air conditioning went out about a month ago (June 2021) and indicated he didn't care if it was replaced. The Maintenance

	Supervisor indicated the facility had not monitored Resident B's room temperature to ensure the temperature maintained at a safe level since the air conditioner stopped working nor had he followed up with the resident to ensure he remained comfortable. During an interview on 7/8/21 at 2:00 p.m., Resident B indicated her room air conditioner stopped working mid June. She indicated the facility said they would replace or repair it but it would take a few days. She indicated the facility did not offered her another room to temporarily stay in during the repair. Lastly she indicated, her room was uncomfortable and she had to leave the facility and stay with family a few days during the air conditioner replacement. Resident B's clinical record was reviewed on 7/8/21 at 10:15 a.m.. Resident B's record indicated she was out of the facility visiting her family on 6/12/21 and 6/13/21. During an interview on 7/8/2021 at 1: 45 p.m., the Director indicated the facility did not have a record of monitoring Resident Cs room temperature to ensure safety after his air conditioner went out nor did they offer Resident B a temporary room with air conditioning while her's was			

	being replaced. This residential tag relates to complaint IN00355849.			
R 0187	Physical Plant Standards - Deficiency 410 IAC 16.2-5-1.6(k) (k) Hot water temperature for all bathing and hand washing facilities shall be controlled by an automatic control valve. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit. Based on observation and interview, the facility failed to ensure water temperatures were maintained at a safe temperature of 120 degrees Fahrenheit (F) or below for 10 of 10 rooms tested for water temperature safety. (Resident Rooms 232, 230, 217, 204, 122, 129, 132, 121, first floor left side common bathroom and first floor kitchenette) Findings include: During an interview on 7/7/2021 at 10: 45 a.m., the Maintenance Supervisor indicated there was one water line supplying water to all resident rooms and all common areas in the facility. During the 7/7/2021, 10:40	R 0187	1.The facility will continue a hot water temperature for all bathing and handwashing controlled by an automatic control valve. Water temperature at point of use will be maintained between 100 degrees Fahrenheit and 120 degrees Fahrenheit. The Maintenance Supervisor reduced the water temperature, during the survey, to between 100 degrees Fahrenheit and 120 degree Fahrenheit. The Maintenance Supervisor, or their designee, will continue to monitor the water temps per the facility policy. 2. All residents had the potential to be affected. The facility will continue a hot water temperature for all bathing and hand washing controlled by an automatic control valve. Water temperature at point of use will be maintained between 100 degrees Fahrenheit and 120 degrees Fahrenheit. The Maintenance Supervisor reduced the water temperature, during the survey, to between 100 degrees Fahrenheit and 120 degree Fahrenheit. The Maintenance Supervisor, or their designee, will continue to monitor the water temps per the facility policy. 3. The Maintenance Supervisor, or their designee, will continue to monitor the facility water temps per facility Preventative Maintenance Program. If they find the water temps are too high or too low they	07/10/2021

	a.m.-11:40 a.m., environmental tour with the Maintenance Supervisor 10 locations were tested for water temperature safety. 10 of 10 areas tested had water temperatures in excess on 120 degrees Fahrenheit (F) as follows: a. Resident room 232 was 127.6 F b. Resident room 230 was 129.0 F c. Resident room 217 was 129.3 F d. Resident room 204 was 131.7 F e. Resident room 122 was 129.4 F f. Resident room 129 was 128.1 F g. Resident room 132 was 129.8 F h. Resident room 121 was 130.6 F i. First floor left side common bathroom was 132.4 F j. First floor kitchenette was 130.6 F During the 7/7/2021, 11:30 a.m., environmental tour with the Maintenance Supervisor, the mixing valve read 129.5 degrees Fahrenheit. During an		will adjust the temps to meet the requirements. 4. The Director, or their designee, will monitor the Preventative Maintenance Program water temps. every 2 weeks for 3 months, then monthly for 3 months. The Maintenance Supervisor, or their designee, will monitor the water temps monthly per the preventative maintenance program. If there are any problems maintaining the water at the correct temperatures the Administrator, or their designee, will be notified to assist in the correction of the water temps.	

interview at this time, the Maintenance Supervisor indicated he maintained the water temperature at higher than 120 degrees because the water lost temperature as it traveled through the pipes and the residents desired 120 degree water at the point of service. He additionally indicated he routinely monitored the water temperatures and had never had temperatures in excess of 120 degrees Fahrenheit.

This residential tag relates to complaint IN00355849.

Based on observation and interview, the facility failed to ensure water temperatures were maintained at a safe temperature of 120 degrees Fahrenheit (F) or below for 10 of 10 rooms tested for water temperature safety. (Resident Rooms 232, 230, 217, 204, 122, 129, 132, 121, first floor left side common bathroom and first floor kitchenette)

Findings include:

During an interview on 7/7/2021 at 10: 45 a.m., the Maintenance Supervisor indicated there was one water line supplying water to all resident rooms and all common areas in the facility.

During the 7/7/2021, 10:40 a.m.-11:40 a.m., environmental tour with the Maintenance

	Supervisor 10 locations were tested for water temperature safety. 10 of 10 areas tested had water temperatures in excess on 120 degrees Fahrenheit (F) as follows: a. Resident room 232 was 127.6 F b. Resident room 230 was 129.0 F c. Resident room 217 was 129.3 F d. Resident room 204 was 131.7 F e. Resident room 122 was 129.4 F f. Resident room 129 was 128.1 F g. Resident room 132 was 129.8 F h. Resident room 121 was 130.6 F i. First floor left side common bathroom was 132.4 F j. First floor kitchenette was 130.6 F During the 7/7/2021, 11:30 a.m., environmental tour with the Maintenance Supervisor, the mixing valve read 129.5 degrees Fahrenheit. During an interview at this time, the Maintenance Supervisor			

	indicated he maintained the water temperature at higher than 120 degrees because the water lost temperature as it traveled through the pipes and the residents desired 120 degree water at the point of service. He additionally indicated he routinely monitored the water temperatures and had never had temperatures in excess of 120 degrees Fahrenheit. This residential tag relates to complaint IN00355849.			
R 0214	Evaluation - Deficiency 410 IAC 16.2-5-2(a) (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview the facility failed to complete semi-annual evaluations for 4 of 4 residents reviewed. (Resident D, 2, C, and B). Findings include: 1. The clinical record for Resident D was reviewed on	R 0214	1, The facility will continue to do an evaluation of the individual needs of each resident which will be initiated prior to admission and shall be updated at least semi-annually and upon a substantial change in the resident's condition, or more often at the resident's or facilities request. Resident's D, 2, C, and B have had their semi-annual evaluations completed. 2. All residents had the potential to be affected. The DON has updated all residents semi-annual evaluations. The facility will continue to do an evaluation of the individual needs of each resident which will be initiated prior to admission and shall be updated at least semi-annually and upon a substantial change in the resident's condition, or more often at the resident's or facilities request. 3. A policy is in place for Resident Semi-Annual Assessments. The	08/31/2021

	7/8/21. Diagnoses for the resident included, but were not limited to, amputation above the knee, and chronic obstruction pulmonary disease. Resident D's admission date 1/31/2020. The clinical record lacked a semi-annual assessment. 2. The clinical record for Resident 2 was reviewed on 7/8/21. Diagnoses for the resident included, but were not limited to, anxiety, and chronic kidney disease. Resident 2's admission date 11/14/2019. The clinical record lacked a semi-annual assessment. 3. The clinical record for Resident C was reviewed on 7/8/21. Diagnoses for the resident included, but were not limited to, major depression, suicidal ideation, peripheral neuropathy. Resident C's admission date 2/4/2000. The clinical record lacked a semi-annual assessment. 4. The clinical record for Resident B was reviewed on 7/8/21. Diagnoses for the resident included, but were not limited to, hypertension and depression. Resident B's admission date		Director of Nursing, or their designee, will review the Resident Semi-Annual Assessment dates monthly and complete any that are due that month. 4. The Assistant Director, or their designee, will review the Resident Semi-Annual Assessment completion dates monthly. for 3 months, then bi-monthly (every 2 months) for 3 months. Then the DON, or their designee, will continue to complete the Resident Semi-Annual Assessment every 6 month as required. If problems occur the Assistant Director, or their designee, will report these to the Director, or their designee. If the Director, or their designee, has a problem correcting the issue, they will notify the Administrator, or their designee, for help in correcting the issue.	

	3/6/2010. The clinical record lacked a semi-annual assessment. During a 7/9/21, 11:30 a.m., interview, the Director indicated the facility did not have Semi-Annual Assessments for Residents D, 2, B or C. She additionally indicated the facility did not have a policy for Semi-Annual Assessments. Based on record review and interview the facility failed to complete semi-annual evaluations for 4 of 4 residents reviewed. (Resident D, 2, C, and B). Findings include: 1. The clinical record for Resident D was reviewed on 7/8/21. Diagnoses for the resident included, but were not limited to, amputation above the knee, and chronic obstruction pulmonary disease. Resident D's admission date 1/31/2020. The clinical record lacked a semi-annual assessment. 2. The clinical record for Resident 2 was reviewed on 7/8/21. Diagnoses for the resident included, but were not limited to, anxiety, and chronic kidney disease. Resident 2's admission date 11/14/2019. The clinical record			

	lacked a semi-annual assessment. 3. The clinical record for Resident C was reviewed on 7/8/21. Diagnoses for the resident included, but were not limited to, major depression, suicidal ideation, peripheral neuropathy. Resident C's admission date 2/4/2000. The clinical record lacked a semi-annual assessment. 4. The clinical record for Resident B was reviewed on 7/8/21. Diagnoses for the resident included, but were not limited to, hypertension and depression. Resident B's admission date 3/6/2010. The clinical record lacked a semi-annual assessment. During a 7/9/21, 11:30 a.m., interview, the Director indicated the facility did not have Semi-Annual Assessments for Residents D, 2, B or C. She additionally indicated the facility did not have a policy for Semi-Annual Assessments.			
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in	R 0216	1. Residents 5 and 6 cannot safely self-administer their own medication. Resident D cannot safely self-administer her own oral medications, she has been approved to self- administer her	08/31/2021

	the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, record review, and interview the facility failed to ensure residents were safe for self administration for 3 of 3 residents observed during medication pass. (Residents D, 5, and 6). Findings include: During the medication pass observation on 7/8/21 at 9:00 a.m., the following was observed: a. QMA 6 prepared Resident 5's morning medication. Resident 5 was sitting in the dining room eating breakfast. QMA 6 sat the residents medication cup on the table and walked back to the medication cart located at the		inhaler and her vaginal cream, as ordered by her physician. QMA 6 has been instructed in the proper way to pass and document medications. 2. All residents had the potential to be affected. QMA 6 has been instructed in the proper way to pass and document medications. 3. All new QMAs will be correctly orientated to the proper passing and documentation of medication, per facility policy. 4. The Director of Nursing, or their designee, will monitor the new employee orientation of QMAs as it pertains to medication passing and documentation, monthly for 3 months, then bimonthly for 3 months. The Assistant Director , or their designee, will continue to check new QMA's orientation forms to ensure they are completed as required. This is ongoing. The DON, or their designee, will notify the Director, or their designee, if any issues occur. The Director, or their designee, will contact the Administrator, or their designee, if any issues occur that they need their assistance is correcting.	

	end of the hall out of site of the resident. She did not observe the resident take the medication. No staff were in site of the resident. b. QMA 6 prepared Resident 6's morning medication, Resident 6 was sitting in the dining room eating breakfast. QMA 6 sat the residents medication cup on the table and walked back to the medication cart located at the end of the hall out of site of the resident. She did not observe the resident take the medication. No staff were in site of the resident. c. During Resident D's medication pass observation, QMA 6 marked the medication administration form indicating she had administered an inhaler to another resident, she did not administrator an inhaler during the observation. During an interview on 7/8/21 at 10:10 a.m., QMA 6 indicted Resident D self administered the inhaler her room. She indicated she had always left the medicine with Residents 5 and 6. She indicated she had been employed for two weeks and was trained to leave the medicine when they were in the dining room. 1. A review of Resident 5's self administration of medication assessment, dated 1/31/21,			

indicated the resident was unable to safely self-administer medication.

2. A review of Resident 6's self administration of medication assessment, dated 1/31/21, indicated the resident was unable to safely self-administer medication.

3. A review of Resident D's self administration of medication assessment, dated 1/31/21, the resident was unable to safely self-administer medication.

A review of facility policy undated, titled "Resident Management and Self-administration of Medication" provided by the Assistant Director on 7/8/21 at 3:52 p.m., included but was not limited to, "Each resident who desires to manage and self-administer their own medication is permitted to do so if it is determined that the practice would be safe for the resident...

Residents who are assessed as safe to manage and self-administer their own medication will be permitted to keep their mediation in their own apartment/room..."

Based on observation, record review, and interview the facility failed to ensure residents were safe for self administration for 3 of 3 residents observed during

	medication pass. (Residents D, 5, and 6). Findings include: During the medication pass observation on 7/8/21 at 9:00 a.m., the following was observed: a. QMA 6 prepared Resident 5's morning medication. Resident 5 was sitting in the dining room eating breakfast. QMA 6 sat the residents medication cup on the table and walked back to the medication cart located at the end of the hall out of site of the resident. She did not observe the resident take the medication. No staff were in site of the resident. b. QMA 6 prepared Resident 6's morning medication, Resident 6 was sitting in the dining room eating breakfast. QMA 6 sat the residents medication cup on the table and walked back to the medication cart located at the end of the hall out of site of the resident. She did not observe the resident take the medication. No staff were in site of the resident.			

	c. During Resident D's medication pass observation, QMA 6 marked the medication administration form indicating she had administered an inhaler to another resident, she did not administrator an inhaler during the observation. During an interview on 7/8/21 at 10:10 a.m., QMA 6 indicted Resident D self administered the inhaler her room. She indicated she had always left the medicine with Residents 5 and 6. She indicated she had been employed for two weeks and was trained to leave the medicine when they were in the dining room. 1. A review of Resident 5's self administration of medication assessment, dated 1/31/21, indicated the resident was unable to safely self-administer medication. 2. A review of Resident 6's self administration of medication assessment, dated 1/31/21, indicated the resident was unable to safely self-administer medication. 3. A review of Resident D's self administration of medication assessment, dated 1/31/21, the resident was unable to safely self-administer medication. A review of facility policy undated, titled "Resident Management and			

	Self-administration of Medication" provided by the Assistant Director on 7/8/21 at 3:52 p.m., included but was not limited to, "Each resident who desires to manage and self-administer their own medication is permitted to do so if it is determined that the practice would be safe for the resident... Residents who are assessed as safe to manage and self-administer their own medication will be permitted to keep their mediation in their own apartment/room..."			
R 0268	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(a) (a) The facility shall provide, arrange, or make available three (3) well-planned meals a day, seven (7) days a week that provide a balanced distribution of the daily nutritional requirements. Based on observation, interview, and record review, the facility failed to have recipes and portion sizes guidance to ensure the nutritive needs of residents were met. Findings include: During the 7/7/21, 9:22 a.m., kitchen tour, no menus, recipes, or portion size guides were	R 0268	1. All residents had the potential to be affected by the alleged deficient practice. The facility is in the process of obtaining a contract with Groves Menus for Assisted Living. These menus are dietitian approved and have recipes, portion sizes and will ensure the nutritive needs of the residents are met. 2. All residents had the potential to be affected by the alleged deficient practice. The facility is in the process of obtaining a contract with Groves Menus for Assisted Living. These menus are dietitian approved and have recipes, portion sizes and will ensure the nutritive needs of the residents are met.	09/15/2021

	observed in the kitchen. During an interview on 7/8/21 at 12: 46 p.m., Dietary Aide 3, who had just served meal trays, was asked about potion sized guidance. He indicated they used their judgment for portion size. He also indicated he did not know of any recipes in the facility. During a 7/8/21, 12:50 p.m., interview the Assistant Director, who was identified as temporarily overseeing the dietary department, indicated the facility had no menus or recipes, nor did they have guidance for portion sizes or identified alternates of equal nutritive value. She also indicated the facility did not have a Registered Dietitian. This residential tag relates to complaint IN00356074. Based on observation, interview, and record review, the facility failed to have recipes and portion sizes guidance to ensure the nutritive needs of residents were met. Findings include: During the 7/7/21, 9:22 a.m., kitchen tour, no menus, recipes, or portion size guides were observed in the kitchen. During an interview on 7/8/21 at 12: 46 p.m., Dietary Aide 3, who		3. The Director, or their designee, will monitor the dietary menus to ensure the menus are dietitian approved and have recipes, portion sizes and will ensure the nutritive needs of the residents are met. 4. The Assistant Director, or their designee, will audit the dietary menus to ensure they meet all of the requirements, monthly for 3 months, then bimonthly for 3 months. Then they will review new menus as they are received, this will be ongoing. The Assistant Director, or their designee, will report to the Director, or their designee, if any issues arise that need their assistance in correcting. If issues occur or continue, that need further assistance to correct, the Director, or their designee, will notify the Administrator, or their designee, for assistance in correction.	

	had just served meal trays, was asked about potion sized guidance. He indicated they used their judgment for portion size. He also indicated he did not know of any recipes in the facility. During a 7/8/21, 12:50 p.m., interview the Assistant Director, who was identified as temporarily overseeing the dietary department, indicated the facility had no menus or recipes, nor did they have guidance for portion sizes or identified alternates of equal nutritive value. She also indicated the facility did not have a Registered Dietitian. This residential tag relates to complaint IN00356074.			
R 0269	Food and Nutritional Services - Noncompliance 410 IAC 16.2-5-5.1(b) (b) The menu or substitutions, or both, for all meals shall be approved by a registered dietician. Based on observation, interview and record review, the facility failed to have menus and alternates which were prepared by a Registered Dietitian. Findings include: During the 7/7/21, 9:22 a.m., kitchen tour, no menus, recipes,	R 0269	1. All residents had the potential to be affected by the alleged deficiency. All residents had the potential to be affected by the alleged deficient practice.The facility is in the process of obtaining a contract with Groves Menus for Assisted Living. These menus and alternates are prepared by a registered dietitian. The residents are given a menu for each meal, these have the food choice for the next days meal. The resident makes their choice for their meal from the menu items listed. Some residents do call the menu a ticket. 2. All residents had the potential to be affected by the alleged deficient	09/15/2021

	or portion size guides were observed in the kitchen. During an interview on 7/8/21 at 12:46 p.m., interview, Dietary Aide 3, who had just served meal trays, was asked where menus, potion sized guides and recipe were kept. He indicated he didn't know. He indicated staff just served what was written down as the menu for the day, but there was no guidance about portion sizes. He indicated he was unaware of any recipes in the facility. He indicated staff used their judgment for portion size. During an interview on 7/8/21 at 12:50 p.m., interview the Assistant Director, who was identified as temporarily overseeing the dietary department, indicated the facility had no menus, recipes which were developed by a Registered Dietitian, nor did they have guidance for portion sizes or identified alternates of equal nutritive value. She also indicated the facility did not have a registered dietitian.		practice.The facility is in the process of obtaining a contract with Groves Menus for Assisted Living. These menus and alternates are prepared by a registered dietitian. The residents are given a menu for each meal, these have the food choice for the next days meal. The resident makes their choice for their meal from the menu items listed. Some residents do call the menu a ticket.3. The Director, or their designee, will monitor The Groves Menus to ensure they meet the requirements of being prepared by a registered dietitian and offer alternates. 4. The Assistant Director, or their designee, will monitor the Groves Menus to ensure they have been prepared by a registered dietitian and include alternates, monthly for 3 months, then bimonthly for 3 months. The Assistant Director, or their designee, will report any issues with the menus to the Director, or their designee, for correction. If the Director, or their designee, cannot correct the issues, they will notify the Administrator, or their designee, for assistance in correction of any issues.	

During an interview on 7/8/21 at 2:06 p.m., Resident D indicated there were no menus to look at. A ticket was left at the table before every meal for the residents to choose their food from. She indicated there were no alternates and the a la carte was what was on the salad bar.

This residential tag relates to complaint IN00356074.

Based on observation, interview and record review, the facility failed to have menus and alternates which were prepared by a Registered Dietitian.

Findings include:

During the 7/7/21, 9:22 a.m., kitchen tour, no menus, recipes, or portion size guides were observed in the kitchen.

During an interview on 7/8/21 at 12:46 p.m., interview, Dietary Aide 3, who had just served meal trays, was asked where menus, potion sized guides and recipe were kept. He indicated he didn't know. He indicated staff just served what was written down as the menu for the day, but there was no guidance about portion sizes. He indicated he was unaware of any recipes in the facility. He indicated staff used their judgment for portion size.

During an interview on 7/8/21 at 12:50 p.m., interview the

	Assistant Director, who was identified as temporarily overseeing the dietary department, indicated the facility had no menus, recipes which were developed by a Registered Dietitian, nor did they have guidance for portion sizes or identified alternates of equal nutritive value. She also indicated the facility did not have a registered dietitian. During an interview on 7/8/21 at 2:06 p.m., Resident D indicated there were no menus to look at. A ticket was left at the table before every meal for the residents to choose their food from. She indicated there were no alternates and the a la carte was what was on the salad bar. This residential tag relates to complaint IN00356074. Based on observation, interview and record review, the facility failed to have menus and alternates which were prepared by a Registered Dietitian. Findings include: During the 7/7/21, 9:22 a.m., kitchen tour, no menus, recipes, or portion size guides were observed in the kitchen. During an interview on 7/8/21 at 12:46 p.m., interview, Dietary Aide 3, who had just served meal trays, was asked where menus, potion sized guides and			

	recipe were kept. He indicated he didn't know. He indicated staff just served what was written down as the menu for the day, but there was no guidance about portion sizes. He indicated he was unaware of any recipes in the facility. He indicated staff used their judgment for portion size. During an interview on 7/8/21 at 12:50 p.m., interview the Assistant Director, who was identified as temporarily overseeing the dietary department, indicated the facility had no menus, recipes which were developed by a Registered Dietitian, nor did they have guidance for portion sizes or identified alternates of equal nutritive value. She also indicated the facility did not have a registered dietitian. During an interview on 7/8/21 at 2:06 p.m., Resident D indicated there were no menus to look at. A ticket was left at the table before every meal for the residents to choose their food from. She indicated there were no alternates and the a la carte was what was on the salad bar. This residential tag relates to complaint IN00356074. Based on observation, interview and record review, the facility failed to have menus and alternates which were prepared			

by a Registered Dietitian.

Findings include:

During the 7/7/21, 9:22 a.m., kitchen tour, no menus, recipes, or portion size guides were observed in the kitchen.

During an interview on 7/8/21 at 12:46 p.m., interview, Dietary Aide 3, who had just served meal trays, was asked where menus, potion sized guides and recipe were kept. He indicated he didn't know. He indicated staff just served what was written down as the menu for the day, but there was no guidance about portion sizes. He indicated he was unaware of any recipes in the facility. He indicated staff used their judgment for portion size.

During an interview on 7/8/21 at 12:50 p.m., interview the Assistant Director, who was identified as temporarily overseeing the dietary department, indicated the facility had no menus, recipes which were developed by a Registered Dietitian, nor did they have guidance for portion sizes or identified alternates of equal nutritive value. She also indicated the facility did not have a registered dietitian.

During an interview on 7/8/21 at 2:06 p.m., Resident D indicated there were no menus to look at. A ticket was left at the table

	before every meal for the residents to choose their food from. She indicated there were no alternates and the a la carte was what was on the salad bar. This residential tag relates to complaint IN00356074.			
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. 3. During the dining observation on 7/7/21 at 11:45 a.m., the following was observed: Dietary aide 5 was observed multiple times touching her mask and pushing her glasses up on top of her head, then back to her eyes. She did not change her gloves or use hand sanitizer. She was observed touching the inside of the salad plate from the salad bar with the same gloves she had previously touched her glasses and mask with. She walked to the lounge and placed her hands on her knees while bending over to speak to a resident, then went to the salad bar and proceeded to fix a salad plate again she placed her thumb inside the	R 0273	1. All residents had the potential to be affected by the alleged deficient practice. Dietary staff has been instructed on the proper procedures of sanitation and safe food handling. Cleaning of the food prep areas, equipment monitoring, proper and safe food handling, monitoring temps are all ongoing. 2. All residents had the potential to be affected by the alleged deficient practice. Dietary staff has been instructed on the proper procedures of sanitation and safe food handling. Cleaning of the food prep areas, equipment monitoring, proper and safe food handling, monitoring temps are all ongoing. 3. The Assistant Director, or their designee, will monitor the dietary service, including, safe food handling, sanitation to ensure the alleged deficient practice does not reoccur. 4. The Director, or their designee, will monitor the the dietary service to ensure they follow the state and local sanitation and safe food handling standards. If there are any issues they will report their findings to the Administrator, or their designee, for assistant in correcting any issues.	08/31/2021

plate.

Dietary Aide 7 was observed six times, when she placed the used ice scoop inside the ice cooler on top of the ice, while filling the residents' cups during the meal service.

Dietary aide 3 was observed during the food dipping service, he placed the completed food ticket on the clean plate, as he dipped the food onto the plate, he continuously moved the ticket to different parts of the plate. He picked up the dinner roll with his gloved hand that he had previously handled the utensils, tickets, and plates. He placed the dinner roll on top of the ticket on the plate. He continued with this pattern throughout the meal service, he did not change his gloves or use hand sanitizer.

During an interview on 7/8/21 at 1:05 p.m., the Dietary Aide 7 indicated the ice scoop should not be stored inside the cooler on top of the ice.

During an interview on 7/8/21 at 1:22 p.m., the Dietary Aide 3 indicated he should not place the tickets on the plate, and he should use prongs to pick up the dinner rolls.

4. A current, 3/09, untitled facility policy regarding food temperatures, which was provided by the Assistant

	Director, on 7/8/2021 at 9:15 a.m., indicated the following: "Temperature Abuse 1. Do not let food remain between 41 F and 135 F this is the danger zone 2. Always use an accurate thermometer 3. Record all temperatures of food in a daily log..." A current, 4/09, untitled facility policy regarding kitchen sanitation, which was provided by the Assistant Director on 7/8/21 at 9:15 a.m., indicated the following: "Food Services Associates will clean any areas that are able to reach without using a ladder." A current, 4/09, untitled facility policy regarding dish washer operations, which was provided by the Assistant Director on 7/8/21 at 9:15 a.m., indicated the following: "Washing dishes a properly operating dishwasher and the proper detergent...Daily temperature log is done daily...On a random monthly basis the administrator will complete a review to ensure compliance." A current, 3/09, untitled facility policy regarding kitchen			

	sanitation, which was provided by the Assistant Director on 7/8/21 at 9:15 a.m., indicated the following: "Cross Contamination clean and sanitize all work surfaces, equipment, and utensils after each task." This residential tag relates to complaint IN00356074. Based on observation, interview and record review the facility failed to ensure the food preparation areas were clean and sanitary, equipment was monitored to ensure proper functioning, food was dated, labeled and sealed after opening, foods were dated when received to ensure freshness, food was served at a safe temperature; and safe food handle was practiced during meal service. Findings Include: 1. During a 7/7/21, 9:22 a.m., kitchen sanitation tour the following concerns were noted: a. The can opener, which was mounted to the food preparation table, had sticky black residue on the cutting blade and base. b. The oven had spilled, burnt on and baked on food down the front and on the burner surfaces. The surface was			

sticky to the touch.

c. The exhaust vent over the oven had a heavy dark black dust and grease residue on the lip of the hood.

d. The reach-in refrigerator freezer, which was located in the food preparation area, had open undated of labeled tater tots and breaded chicken strips in the freezer portion. The freezer did not have a thermometer inside or any other method to monitor temperature in the freezer section. The reach-in refrigeration freezer had no temperature log posted on the equipment nor located anywhere within the dietary department.

e. The walk-in refrigerator had a food temperature log posted on the door. The last recorded temperature was dated 5/29/2021. The walk-in refrigerator had undated meat patties with blood pooled on the tray.

f. The walk-in freezer had a food temperature log posted on the door. The last recorded temperature was dated 5/29/2021. There was no freezer log located anywhere within the dietary department. The walk-in freezer contained opened tater tots and sliced potatoes which were not dated when opened.

	g. The dry storage area contained boxes and cans of food that were not dated when received to ensure the oldest product would be used first. The following food items were opened with the tops rolled down and not sealed closed, with no date when opened: taco seasoning, drakes breading, gray mix and a bag of dried pinto beans. There were two rubber containers, each without a lid, left open with out dates or labels containing open unmarked, unsealed flour sacks left open to the air. The flour was uncovered and could be touched with the hand or have items dropped into the container. h. The dishwasher did not have a temperature log. During a 7/7/21, 9:45 a.m., interview, Dietary Aide 3, looked through the record of logs for cleaning, refrigerator temperatures, freezer temperatures, dishwasher temperatures and indicated he could not find any log that had been completed in the past 3 months. He indicated all of these logs should be completed on a daily bases. He indicated he himself had not been complete said logs and felt Dietary Aid 4 should have completed some. During a 7/7/21, 9:48 a.m.,			

	interview, Dietary Aide 4 indicated he did not complete logs and did not know it was his responsibility. 2. During the 7/7/21 lunch, meal observation, the following concerns regarding safe food temperatures were observed: During a 7/7/21, 12:07 p.m., interview, Dietary Aid 4, who had just completed cooking the lunch meal, indicated he had not taken food temperatures before he placed the food in the steam table. He indicated he did not think it was necessary to take the temperature of food which had been removed from a hot oven. He indicated he did not add food temperatures to a log. Lastly, he indicated he believed the dietary employees who served the food at the steam table recorded temperatures in a log. He also indicated he was unaware of the location of any thermometer to test food temperatures. During a 7/7/21, 12:11 p.m., interview, Dietary Aid 3 who was serving the lunch meal, indicated he did not have a thermometer to take food temperatures. He indicated he had not had a thermometer in weeks. He indicated he had not taken food temperatures prior to serving the meal. He also indicated he was aware he should record food			

	temperatures in a log prior to each meal. Lastly, he indicated that he had not recorded temperatures in the log for a long time and he could not find a food temperature log for any month in 2021. 3. During the dining observation on 7/7/21 at 11:45 a.m., the following was observed: Dietary aide 5 was observed multiple times touching her mask and pushing her glasses up on top of her head, then back to her eyes. She did not change her gloves or use hand sanitizer. She was observed touching the inside of the salad plate from the salad bar with the same gloves she had previously touched her glasses and mask with. She walked to the lounge and placed her hands on her knees while bending over to speak to a resident, then went to the salad bar and proceeded to fix a salad plate again she placed her thumb inside the plate. Dietary Aide 7 was observed six times, when she placed the used ice scoop inside the ice cooler on top of the ice, while filling the residents' cups during the meal service. Dietary aide 3 was observed during the food dipping service, he placed the completed food ticket on the clean plate, as he			

dipped the food onto the plate, he continuously moved the ticket to different parts of the plate. He picked up the dinner roll with his gloved hand that he had previously handled the utensils, tickets, and plates. He placed the dinner roll on top of the ticket on the plate. He continued with this pattern throughout the meal service, he did not change his gloves or use hand sanitizer.

During an interview on 7/8/21 at 1:05 p.m., the Dietary Aide 7 indicated the ice scoop should not be stored inside the cooler on top of the ice.

During an interview on 7/8/21 at 1:22 p.m., the Dietary Aide 3 indicated he should not place the tickets on the plate, and he should use prongs to pick up the dinner rolls.

4. A current, 3/09, untitled facility policy regarding food temperatures, which was provided by the Assistant Director, on 7/8/2021 at 9:15 a.m., indicated the following:

"Temperature Abuse

1. Do not let food remain between 41 F and 135 F this is the danger zone

2. Always use an accurate thermometer

3. Record all temperatures of

	food in a daily log..." A current, 4/09, untitled facility policy regarding kitchen sanitation, which was provided by the Assistant Director on 7/8/21 at 9:15 a.m., indicated the following: "Food Services Associates will clean any areas that are able to reach without using a ladder." A current, 4/09, untitled facility policy regarding dish washer operations, which was provided by the Assistant Director on 7/8/21 at 9:15 a.m., indicated the following: "Washing dishes a properly operating dishwasher and the proper detergent...Daily temperature log is done daily...On a random monthly basis the administrator will complete a review to ensure compliance." A current, 3/09, untitled facility policy regarding kitchen sanitation, which was provided by the Assistant Director on 7/8/21 at 9:15 a.m., indicated the following: "Cross Contamination clean and sanitize all work surfaces, equipment, and utensils after each task."			

This residential tag relates to complaint IN00356074.

Based on observation, interview and record review the facility failed to ensure the food preparation areas were clean and sanitary, equipment was monitored to ensure proper functioning, food was dated, labeled and sealed after opening, foods were dated when received to ensure freshness, food was served at a safe temperature; and safe food handle was practiced during meal service.

Findings Include:

1. During a 7/7/21, 9:22 a.m., kitchen sanitation tour the following concerns were noted:

a. The can opener, which was mounted to the food preparation table, had sticky black residue on the cutting blade and base.

b. The oven had spilled, burnt on and baked on food down the front and on the burner surfaces. The surface was sticky to the touch.

c. The exhaust vent over the oven had a heavy dark black dust and grease residue on the lip of the hood.

d. The reach-in refrigerator freezer, which was located in the food preparation area, had open undated of labeled tater

	tots and breaded chicken strips in the freezer portion. The freezer did not have a thermometer inside or any other method to monitor temperature in the freezer section. The reach-in refrigeration freezer had no temperature log posted on the equipment nor located anywhere within the dietary department. e. The walk-in refrigerator had a food temperature log posted on the door. The last recorded temperature was dated 5/29/2021. The walk-in refrigerator had undated meat patties with blood pooled on the tray. f. The walk-in freezer had a food temperature log posted on the door. The last recorded temperature was dated 5/29/2021. There was no freezer log located anywhere within the dietary department. The walk-in freezer contained opened tater tots and sliced potatoes which were not dated when opened. g. The dry storage area contained boxes and cans of food that were not dated when received to ensure the oldest product would be used first. The following food items were opened with the tops rolled down and not sealed closed, with no date when opened: taco seasoning, drakes breading,			

gray mix and a bag of dried pinto beans. There were two rubber containers, each without a lid, left open with out dates or labels containing open unmarked, unsealed flour sacks left open to the air. The flour was uncovered and could be touched with the hand or have items dropped into the container.

h. The dishwasher did not have a temperature log.

During a 7/7/21, 9:45 a.m., interview, Dietary Aide 3, looked through the record of logs for cleaning, refrigerator temperatures, freezer temperatures, dishwasher temperatures and indicated he could not find any log that had been completed in the past 3 months. He indicated all of these logs should be completed on a daily bases. He indicated he himself had not been complete said logs and felt Dietary Aid 4 should have completed some.

During a 7/7/21, 9:48 a.m., interview, Dietary Aide 4 indicated he did not complete logs and did not know it was his responsibility.

2. During the 7/7/21 lunch, meal observation, the following concerns regarding safe food temperatures were observed:

During a 7/7/21, 12:07 p.m.,

	interview, Dietary Aid 4, who had just completed cooking the lunch meal, indicated he had not taken food temperatures before he placed the food in the steam table. He indicated he did not think it was necessary to take the temperature of food which had been removed from a hot oven. He indicated he did not add food temperatures to a log. Lastly, he indicated he believed the dietary employees who served the food at the steam table recorded temperatures in a log. He also indicated he was unaware of the location of any thermometer to test food temperatures. During a 7/7/21, 12:11 p.m., interview, Dietary Aid 3 who was serving the lunch meal, indicated he did not have a thermometer to take food temperatures. He indicated he had not had a thermometer in weeks. He indicated he had not taken food temperatures prior to serving the meal. He also indicated he was aware he should record food temperatures in a log prior to each meal. Lastly, he indicated that he had not recorded temperatures in the log for a long time and he could not find a food temperature log for any month in 2021.			

	3. During the dining observation on 7/7/21 at 11:45 a.m., the following was observed: Dietary aide 5 was observed multiple times touching her mask and pushing her glasses up on top of her head, then back to her eyes. She did not change her gloves or use hand sanitizer. She was observed touching the inside of the salad plate from the salad bar with the same gloves she had previously touched her glasses and mask with. She walked to the lounge and placed her hands on her knees while bending over to speak to a resident, then went to the salad bar and proceeded to fix a salad plate again she placed her thumb inside the plate. Dietary Aide 7 was observed six times, when she placed the used ice scoop inside the ice cooler on top of the ice, while filling the residents' cups during the meal service. Dietary aide 3 was observed during the food dipping service, he placed the completed food ticket on the clean plate, as he dipped the food onto the plate, he continuously moved the ticket to different parts of the plate. He picked up the dinner roll with his gloved hand that he had previously handled the utensils, tickets, and plates. He placed the dinner roll on top of			

	the ticket on the plate. He continued with this pattern throughout the meal service, he did not change his gloves or use hand sanitizer. During an interview on 7/8/21 at 1:05 p.m., the Dietary Aide 7 indicated the ice scoop should not be stored inside the cooler on top of the ice. During an interview on 7/8/21 at 1:22 p.m., the Dietary Aide 3 indicated he should not place the tickets on the plate, and he should use prongs to pick up the dinner rolls. 4. A current, 3/09, untitled facility policy regarding food temperatures, which was provided by the Assistant Director, on 7/8/2021 at 9:15 a.m., indicated the following: "Temperature Abuse 1. Do not let food remain between 41 F and 135 F this is the danger zone 2. Always use an accurate thermometer 3. Record all temperatures of food in a daily log..."			

	A current, 4/09, untitled facility policy regarding kitchen sanitation, which was provided by the Assistant Director on 7/8/21 at 9:15 a.m., indicated the following: "Food Services Associates will clean any areas that are able to reach without using a ladder." A current, 4/09, untitled facility policy regarding dish washer operations, which was provided by the Assistant Director on 7/8/21 at 9:15 a.m., indicated the following: "Washing dishes a properly operating dishwasher and the proper detergent...Daily temperature log is done daily...On a random monthly basis the administrator will complete a review to ensure compliance." A current, 3/09, untitled facility policy regarding kitchen sanitation, which was provided by the Assistant Director on 7/8/21 at 9:15 a.m., indicated the following: "Cross Contamination clean and sanitize all work surfaces, equipment, and utensils after each task." This residential tag relates to complaint IN00356074. Based on observation, interview			

	and record review the facility failed to ensure the food preparation areas were clean and sanitary, equipment was monitored to ensure proper functioning, food was dated, labeled and sealed after opening, foods were dated when received to ensure freshness, food was served at a safe temperature; and safe food handle was practiced during meal service. Findings Include: 1. During a 7/7/21, 9:22 a.m., kitchen sanitation tour the following concerns were noted: a. The can opener, which was mounted to the food preparation table, had sticky black residue on the cutting blade and base. b. The oven had spilled, burnt on and baked on food down the front and on the burner surfaces. The surface was sticky to the touch. c. The exhaust vent over the oven had a heavy dark black dust and grease residue on the lip of the hood. d. The reach-in refrigerator freezer, which was located in the food preparation area, had open undated of labeled tater tots and breaded chicken strips in the freezer portion. The freezer did not have a thermometer inside or any other			

	method to monitor temperature in the freezer section. The reach-in refrigeration freezer had no temperature log posted on the equipment nor located anywhere within the dietary department. e. The walk-in refrigerator had a food temperature log posted on the door. The last recorded temperature was dated 5/29/2021. The walk-in refrigerator had undated meat patties with blood pooled on the tray. f. The walk-in freezer had a food temperature log posted on the door. The last recorded temperature was dated 5/29/2021. There was no freezer log located anywhere within the dietary department. The walk-in freezer contained opened tater tots and sliced potatoes which were not dated when opened. g. The dry storage area contained boxes and cans of food that were not dated when received to ensure the oldest product would be used first. The following food items were opened with the tops rolled down and not sealed closed, with no date when opened: taco seasoning, drakes breading, gray mix and a bag of dried pinto beans. There were two rubber containers, each without a lid, left open with out dates or			

labels containing open unmarked, unsealed flour sacks left open to the air. The flour was uncovered and could be touched with the hand or have items dropped into the container.

h. The dishwasher did not have a temperature log.

During a 7/7/21, 9:45 a.m., interview, Dietary Aide 3, looked through the record of logs for cleaning, refrigerator temperatures, freezer temperatures, dishwasher temperatures and indicated he could not find any log that had been completed in the past 3 months. He indicated all of these logs should be completed on a daily bases. He indicated he himself had not been complete said logs and felt Dietary Aid 4 should have completed some.

During a 7/7/21, 9:48 a.m., interview, Dietary Aide 4 indicated he did not complete logs and did not know it was his responsibility.

2. During the 7/7/21 lunch, meal observation, the following concerns regarding safe food temperatures were observed:

During a 7/7/21, 12:07 p.m., interview, Dietary Aid 4, who had just completed cooking the lunch meal, indicated he had not taken food temperatures

	before he placed the food in the steam table. He indicated he did not think it was necessary to take the temperature of food which had been removed from a hot oven. He indicated he did not add food temperatures to a log. Lastly, he indicated he believed the dietary employees who served the food at the steam table recorded temperatures in a log. He also indicated he was unaware of the location of any thermometer to test food temperatures. During a 7/7/21, 12:11 p.m., interview, Dietary Aid 3 who was serving the lunch meal, indicated he did not have a thermometer to take food temperatures. He indicated he had not had a thermometer in weeks. He indicated he had not taken food temperatures prior to serving the meal. He also indicated he was aware he should record food temperatures in a log prior to each meal. Lastly, he indicated that he had not recorded temperatures in the log for a long time and he could not find a food temperature log for any month in 2021. 3. During the dining observation on 7/7/21 at 11:45 a.m., the following was observed: Dietary aide 5 was observed multiple times touching her mask and pushing her glasses			

	up on top of her head, then back to her eyes. She did not change her gloves or use hand sanitizer. She was observed touching the inside of the salad plate from the salad bar with the same gloves she had previously touched her glasses and mask with. She walked to the lounge and placed her hands on her knees while bending over to speak to a resident, then went to the salad bar and proceeded to fix a salad plate again she placed her thumb inside the plate. Dietary Aide 7 was observed six times, when she placed the used ice scoop inside the ice cooler on top of the ice, while filling the residents' cups during the meal service. Dietary aide 3 was observed during the food dipping service, he placed the completed food ticket on the clean plate, as he dipped the food onto the plate, he continuously moved the ticket to different parts of the plate. He picked up the dinner roll with his gloved hand that he had previously handled the utensils, tickets, and plates. He placed the dinner roll on top of the ticket on the plate. He continued with this pattern throughout the meal service, he did not change his gloves or use hand sanitizer. During an interview on 7/8/21 at			

	1:05 p.m., the Dietary Aide 7 indicated the ice scoop should not be stored inside the cooler on top of the ice. During an interview on 7/8/21 at 1:22 p.m., the Dietary Aide 3 indicated he should not place the tickets on the plate, and he should use prongs to pick up the dinner rolls. 4. A current, 3/09, untitled facility policy regarding food temperatures, which was provided by the Assistant Director, on 7/8/2021 at 9:15 a.m., indicated the following: "Temperature Abuse 1. Do not let food remain between 41 F and 135 F this is the danger zone 2. Always use an accurate thermometer 3. Record all temperatures of food in a daily log..." A current, 4/09, untitled facility policy regarding kitchen sanitation, which was provided by the Assistant Director on 7/8/21 at 9:15 a.m., indicated the following: "Food Services Associates will clean any areas that are able to reach without using a ladder." A current, 4/09, untitled facility policy regarding dish washer			

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	Based on observation, interview and record review the facility failed to ensure the food preparation areas were clean and sanitary, equipment was monitored to ensure proper functioning, food was dated, labeled and sealed after opening, foods were dated when received to ensure freshness, food was served at a safe temperature; and safe food handle was practiced during meal service. Findings Include: 1. During a 7/7/21, 9:22 a.m., kitchen sanitation tour the following concerns were noted: a. The can opener, which was mounted to the food preparation table, had sticky black residue on the cutting blade and base. b. The oven had spilled, burnt on and baked on food down the front and on the burner surfaces. The surface was sticky to the touch. c. The exhaust vent over the oven had a heavy dark black dust and grease residue on the lip of the hood. d. The reach-in refrigerator freezer, which was located in the food preparation area, had open undated of labeled tater tots and breaded chicken strips in the freezer portion. The freezer did not have a			

	thermometer inside or any other method to monitor temperature in the freezer section. The reach-in refrigeration freezer had no temperature log posted on the equipment nor located anywhere within the dietary department. e. The walk-in refrigerator had a food temperature log posted on the door. The last recorded temperature was dated 5/29/2021. The walk-in refrigerator had undated meat patties with blood pooled on the tray. f. The walk-in freezer had a food temperature log posted on the door. The last recorded temperature was dated 5/29/2021. There was no freezer log located anywhere within the dietary department. The walk-in freezer contained opened tater tots and sliced potatoes which were not dated when opened. g. The dry storage area contained boxes and cans of food that were not dated when received to ensure the oldest product would be used first. The following food items were opened with the tops rolled down and not sealed closed, with no date when opened: taco seasoning, drakes breading, gray mix and a bag of dried pinto beans. There were two rubber containers, each without			

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During a 7/7/21, 9:45 a.m., interview, Dietary Aide 3, looked through the record of logs for cleaning, refrigerator temperatures, freezer temperatures, dishwasher temperatures and indicated he could not find any log that had been completed in the past 3 months. He indicated all of these logs should be completed on a daily bases. He indicated he himself had not been complete said logs and felt Dietary Aid 4 should have completed some.

During a 7/7/21, 9:48 a.m., interview, Dietary Aide 4 indicated he did not complete logs and did not know it was his responsibility.

2. During the 7/7/21 lunch, meal observation, the following concerns regarding safe food temperatures were observed:

During a 7/7/21, 12:07 p.m., interview, Dietary Aid 4, who had just completed cooking the lunch meal, indicated he had

	not taken food temperatures before he placed the food in the steam table. He indicated he did not think it was necessary to take the temperature of food which had been removed from a hot oven. He indicated he did not add food temperatures to a log. Lastly, he indicated he believed the dietary employees who served the food at the steam table recorded temperatures in a log. He also indicated he was unaware of the location of any thermometer to test food temperatures. During a 7/7/21, 12:11 p.m., interview, Dietary Aid 3 who was serving the lunch meal, indicated he did not have a thermometer to take food temperatures. He indicated he had not had a thermometer in weeks. He indicated he had not taken food temperatures prior to serving the meal. He also indicated he was aware he should record food temperatures in a log prior to each meal. Lastly, he indicated that he had not recorded temperatures in the log for a long time and he could not find a food temperature log for any month in 2021.			
R 0274	Food and Nutritional Services - Noncompliance 410 IAC 16.2-5-5.1(g)(1-3)	R 0274	1. All residents had the potential to be affected by this alleged deficient practice. A Dietary Manager who is a graduate of an accredited college with a degree in foods and nutrition	09/20/2021

	(g) There shall be an organized food service department directed by a supervisor competent in food service management and knowledgeable in sanitation standards, food handling, food preparation, and meal service. (1) The supervisor must be one (1) of the following: (A) A dietitian. (B) A graduate or student enrolled in and within one (1) year from completing a division approved, minimum ninety (90) hour classroom instruction course that provides classroom instruction in food service supervision who has a minimum of one (1) year of experience in some aspect of institutional food service management. (C) A graduate of a dietetic technician program approved by the American Dietetic Association. (D) A graduate of an accredited college or university or within one (1) year of graduating from an accredited college or university with a degree in foods and nutrition or food administration with a minimum of one (1) year of experience in some aspect of food service management. (E) An individual with training and experience in food service supervision and management. (2) If the supervisor is not a dietitian, a dietitian shall provide consultant services on the premises at peak periods of operation on a regularly scheduled		is in the process of being hired. She is unavailable until after 09/16/2021. Until the Dietary Manager can begin work in this facility, the Assistant Director, or their designee, will continue to be responsible for the oversite of the dietary department. We have advertised for a CDM with no results. A previous employee had enrolled in training for their CDM but then resigned before completing the course. It is extremely hard to find an applicant for the position of CDM. 2. All residents had the potential to be affected by this alleged deficient practice. A Dietary Manager who is a graduate of an accredited college with a degree in foods and nutrition is in the process of being hired. She is unavailable until after 09/16/2021. Until the Dietary Manager can begin work in this facility, the Assistant Director, or their designee, will continue to be responsible for the oversite of the dietary department. We have advertised for a CDM with no results. A previous employee had enrolled in training for their CDM but then resigned before completing the course. It is extremely hard to find an applicant for the position of CDM. 3.The Assistant Director, or their designee, will continue to monitor the dietary department. After a Dietary Manager begins their employment the Assistant Director, or their designee, will continue to monitor the dietary department. 4. The Assistant Director, or their designee, will monitor the dietary department. If any issues in the	

	basis. (3) Food service staff shall be on duty to ensure proper food preparation, serving, and sanitation. Based on observation, interview and record review, the facility failed to employ a qualified food services director. Findings include: During a 7/7/21, 9:22 a.m., kitchen sanitation tour two dietary employees were in the kitchen (Dietary Aids 3 and 4). During a 7/7/21, 9:22 a.m., interview, both Dietary Aid 3 and 4 indicated they were not the individual in charge of the kitchen or the meal preparation. Both Dietary Aids indicated there was no current Food Services Supervisor and the Assistant Director was overseeing the dietary department. During an interview on 7/7/21 at 10:20 a.m., the Director indicated the facility did not have a Food Services Supervisor and the Assistant Director was currently responsible for oversight of the dietary department. During a 7/7/21, 10:23 a.m., interview, the Assistant Director indicated she had been overseeing the dietary department for less than a		employment of a Dietary Manager arises they will report these issues to the Director, or their designee, for assistance in correction of the issues. If the Director, or their designee, cannot correct the issue they will notify the Administrator, or their, designee, for their assistance in correcting the issue.	

week. She indicated she had yet to do a complete walk through of the dietary department since she became responsible for its oversight. She also indicated she was not a certified dietary manager nor did she had training such as a Serve Safe Certification.

Review of the Employee Record Form completed by the facility on 7/7/202, contained no individual listed as the Food Services Supervisor.

During a 7/9/21, 11:05 a.m., interview, the Director indicated the previous Food Services Supervisor was not a trained Dietary Manager nor did the facility have a record of him having any training. She additionally indicated the facility did not have a record of a trained Dietary Manager for over a year or longer.

This residential tag relates to complaint IN00356074.

Based on observation, interview and record review, the facility failed to employ a qualified food services director.

Findings include:

During a 7/7/21, 9:22 a.m., kitchen sanitation tour two dietary employees were in the kitchen (Dietary Aids 3 and 4). During a 7/7/21, 9:22 a.m., interview, both Dietary Aid 3 and

	4 indicated they were not the individual in charge of the kitchen or the meal preparation. Both Dietary Aids indicated there was no current Food Services Supervisor and the Assistant Director was overseeing the dietary department. During an interview on 7/7/21 at 10:20 a.m., the Director indicated the facility did not have a Food Services Supervisor and the Assistant Director was currently responsible for oversight of the dietary department. During a 7/7/21, 10:23 a.m., interview, the Assistant Director indicated she had been overseeing the dietary department for less than a week. She indicated she had yet to do a complete walk through of the dietary department since she became responsible for its oversight. She also indicated she was not a certified dietary manager nor did she had training such as a Serve Safe Certification. Review of the Employee Record Form completed by the facility on 7/7/202, contained no individual listed as the Food Services Supervisor. During a 7/9/21, 11:05 a.m., interview, the Director indicated the previous Food Services			

	Supervisor was not a trained Dietary Manager nor did the facility have a record of him having any training. She additionally indicated the facility did not have a record of a trained Dietary Manager for over a year or longer. This residential tag relates to complaint IN00356074.			
R 0326	Activities Programs - Deficiency 410 IAC 16.2-5-7.1(a) (a) The facility shall provide activities programs appropriate to the abilities and interests of the residents being served. Based on observation, interview the facility failed to offer an activity program. Findings include: During the 7/7/21, 9:20 a.m., entrance conference, the Director was asked to provide three months (May, June, July 2021) of Activity Calendars for review. During an interview on 7/7/21 at 2:15 p.m., the Director indicated the facility did not have any activity calendars for the last three months.	R 0326	1. All residents had the potential to be affected by the alleged deficient practice. The facility has hired an Activity Director who shall provide activity programs appropriate to the abilities and interests of the residents being served. Activity Calendar for August was prepared and posted in each residents room and in a common area. 2. All residents had the potential to be affected by the alleged deficient practice. The facility has hired an Activity Director who shall provide activity programs appropriate to the abilities and interests of the residents being served. 3. The Director, or their designee, will monitor the activity program to ensure that activity calendars are completed and posted, that activities are conducted as planned. 4. The Director, or their designee, will monitor the Activities Program to ensure activities are being conducted as planned, monthly for 3 months, then bimonthly for 3 months. The Activities Director, or their designee, will continue to provide a copy of the monthly	08/31/2021

	During initial tour on 7/7/21 at 9:10 a.m., the activity board was blank. No activites were writen on the board at any time on 7/7/21 or 7/8/21. Review of the Employee Record Form completed by the facility on 7/7/202, contained no individual listed as the Activity Director. During a 7/8/21, 9:30 a.m., interview, the Director indicated the facility did not have an Activity Director. She also indicated when a particular CNA worked she offers activities. She also indicated, no other employee offered activities. Lastly she indicated that activities were written on the bulletined board each day. On 7/8/21 at 1:40 p.m., Resident 26 indicated there were no activities in a couple of weeks, and the activity board had all the activities for the day wrote on it, that was the only way we knew what was going on. She indicated she had not had an activity calendar she was admitted in April 2021. During an interview on 7/8/21 at 2:06 p.m., Resident 1 indicated there was no activity director. she indicated there were no bingo prizes so they have not played bingo for a few weeks. She indicated the TV in the main lounge did not work because the facility did not pay the cable bill and they do not		activity calendar to the Director, or their designee, for review monthly. If the Director, or her designee, has any issues she will report these to the Administrator, or their designee, for assistance in correction. See sample attachment # 20	

	have a movie player anymore, so cannot watch any TV as a group. This residential tag relates to complaint IN00356074. Based on observation, interview the facility failed to offer an activity program. Findings include: During the 7/7/21, 9:20 a.m., entrance conference, the Director was asked to provide three months (May, June, July 2021) of Activity Calendars for review. During an interview on 7/7/21 at 2:15 p.m., the Director indicated the facility did not have any activity calendars for the last three months. During initial tour on 7/7/21 at 9:10 a.m., the activity board was blank. No activites were writen on the board at any time on 7/7/21 or 7/8/21. Review of the Employee Record Form completed by the facility on 7/7/202, contained no individual listed as the Activity Director. During a 7/8/21, 9:30 a.m., interview, the Director indicated the facility did not have an Activity Director. She also indicated when a particular CNA worked she offers activities. She also indicated, no other employee offered activities. Lastly she indicated that activities were written on			

	the bulletined board each day. On 7/8/21 at 1:40 p.m., Resident 26 indicated there were no activities in a couple of weeks, and the activity board had all the activities for the day wrote on it, that was the only way we knew what was going on. She indicated she had not had an activity calendar she was admitted in April 2021. During an interview on 7/8/21 at 2:06 p.m., Resident 1 indicated there was no activity director. she indicated there were no bingo prizes so they have not played bingo for a few weeks. She indicated the TV in the main lounge did not work because the facility did not pay the cable bill and they do not have a movie player anymore, so cannot watch any TV as a group. This residential tag relates to complaint IN00356074.			
R 0328	Activities Programs - Noncompliance 410 IAC 16.2-5-7.1(c)(1-3) (c) An activities director shall be designated and must be one (1) of the following: (1) A recreation therapist. (2) An occupational therapist or a certified occupational therapy assistant.	R 0328	1. A qualified Activity Director has been hired, with a degree as a certified occupational therapy assistant. 2. All residents had the potential to be affected by the alleged deficient practice. A qualified Activity Director has been hired, with a degree as a certified occupational therapy assistant. 3.The Director, or their designee, will monitor the position of Activity	08/31/2021

(3) An individual who has satisfactorily completed or will complete within one (1) year an activities director course approved by the division.

Based on observation, interview and record review, the facility failed to employee an activity director.

Finding Include:

During initial tour on 7/7/21 at 9:10 a.m., the activity board was blank. No activites were writen on the board at any time on 7/7/21 or 7/8/21.

Review of the Employee Record Form completed by the facility on 7/7/202, contained no individual listed as the Activity Director. During a 7/8/21, 9:30 a.m., interview, the Director indicated the facility did not have an Activity Director. She also indicated when a particular CNA worked she offers activities. She also indicated, no other employee offered activities. Lastly she indicated that activities were written on the bulletin board each day.

During the 7/7/21, 9:20 a.m., entrance conference, the Director was asked to provide three months (May, June, July 2021) of Activity Calendars for review. During an interview on 7/7/21 at 2:15 p.m., the Director indicated the facility did not

Director.

4. The Director, or their designee, will monitor the Activity Director, monthly for 3 months, then bimonthly for 3 months. If there are any issues the Director, or there designee, cannot correct without assistance, they will notify the Administrator, or their designee, for assistance in correcting any issues.

	have any activity calendars for the last three months. During a 7/9/21, 11:10 a.m., interview, the Director indicated she did not remember the last time the facility employed an individual who had the certification or education to qualify them as an Activity Director. On 7/8/21 at 1:40 p.m., Resident E indicated no activities in a couple of weeks, and the activity board had all the activities for the day wrote on it, that was the only way we knew what was going on. She indicted she had not had an activity calendar she was admitted in April 2021. During an interview on 7/8/21 at 2:06 p.m., Resident D indicated there was no activity director. she indicated there were no bingo prizes so they have not played bingo for a few weeks. She indicated the TV in the main lounge did not work because the facility did not pay the cable bill and they do not have a movie player anymore, so cannot watch any TV as a group. This residential tag relates to complaint IN00356074.			

Based on observation, interview and record review, the facility failed to employee an activity director.

Finding Include:

During initial tour on 7/7/21 at 9:10 a.m., the activity board was blank. No activites were writen on the board at any time on 7/7/21 or 7/8/21.

Review of the Employee Record Form completed by the facility on 7/7/202, contained no individual listed as the Activity Director. During a 7/8/21, 9:30 a.m., interview, the Director indicated the facility did not have an Activity Director. She also indicated when a particular CNA worked she offers activities. She also indicated, no other employee offered activities. Lastly she indicated that activities were written on the bulletin board each day.

During the 7/7/21, 9:20 a.m., entrance conference, the Director was asked to provide three months (May, June, July 2021) of Activity Calendars for review. During an interview on 7/7/21 at 2:15 p.m., the Director indicated the facility did not have any activity calendars for the last three months.

During a 7/9/21, 11:10 a.m., interview, the Director indicated she did not remember the last time the facility employed an

individual who had the certification or education to qualify them as an Activity Director.

On 7/8/21 at 1:40 p.m., Resident E indicated no activities in a couple of weeks, and the activity board had all the activities for the day wrote on it, that was the only way we knew what was going on. She indicted she had not had an activity calendar she was admitted in April 2021.

During an interview on 7/8/21 at 2:06 p.m., Resident D indicated there was no activity director. she indicated there were no bingo prizes so they have not played bingo for a few weeks. She indicated the TV in the main lounge did not work because the facility did not pay the cable bill and they do not have a movie player anymore, so cannot watch any TV as a group.

This residential tag relates to complaint IN00356074.

Based on observation, interview and record review, the facility failed to employee an activity director.

Finding Include:

During initial tour on 7/7/21 at 9:10 a.m., the activity board was blank. No activites were writen on the board at any time on

7/7/21 or 7/8/21.

Review of the Employee Record Form completed by the facility on 7/7/202, contained no individual listed as the Activity Director. During a 7/8/21, 9:30 a.m., interview, the Director indicated the facility did not have an Activity Director. She also indicated when a particular CNA worked she offers activities. She also indicated, no other employee offered activities. Lastly she indicated that activities were written on the bulletin board each day.

During the 7/7/21, 9:20 a.m., entrance conference, the Director was asked to provide three months (May, June, July 2021) of Activity Calendars for review. During an interview on 7/7/21 at 2:15 p.m., the Director indicated the facility did not have any activity calendars for the last three months.

During a 7/9/21, 11:10 a.m., interview, the Director indicated she did not remember the last time the facility employed an individual who had the certification or education to qualify them as an Activity Director.

On 7/8/21 at 1:40 p.m., Resident E indicated no activities in a couple of weeks, and the activity board had all the activities for the day wrote

on it, that was the only way we knew what was going on. She indicted she had not had an activity calendar she was admitted in April 2021.

During an interview on 7/8/21 at 2:06 p.m., Resident D indicated there was no activity director. she indicated there were no bingo prizes so they have not played bingo for a few weeks. She indicated the TV in the main lounge did not work because the facility did not pay the cable bill and they do not have a movie player anymore, so cannot watch any TV as a group.

This residential tag relates to complaint IN00356074.

Based on observation, interview and record review, the facility failed to employee an activity director.

Finding Include:

During initial tour on 7/7/21 at 9:10 a.m., the activity board was blank. No activites were writen on the board at any time on 7/7/21 or 7/8/21.

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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