STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SWEET GALILEE AT THE WIGWAM	1315 JOHN STREET, 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 the Investigation of Complaint IN00404895. Complaint IN00404895 - State Residential Findings related to the allegations are cited at R0406. Unrelated deficiency is cited. Survey date: March 28 and 29, 2023. Facility number: 014706 Residential Census: 76 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 4, 2023.	R 0000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law. Sweet Galilee at the Wigwam desires this Plan of Correction to be considered the facility's Allegation of Compliance and respectfully requests desk compliance	
R 0057	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(aa)(1-2) (aa) Residents have the right to	R 0057	· *No other residents were affected by the deficient practice. The resident was given her package that had	04/21/2023

	privacy in written communications, including the right to: (1) send and promptly receive mail that is unopened unless the administrator has been instructed otherwise in writing by the resident; and (2) have access to stationery, postage, and writing implements at the resident ' s own expense. Based on interview and record review, the facility failed to ensure a resident received her mail promptly for 1 of 1 resident reviewed for mail delivery (Resident D). Findings include: During an interview with Resident D, on 3/28/23 at 12:40 p.m., she indicated she admitted she had a lot of stuff in her apartment. The Administrator had told her she had the resident's packages, which were delivered to the facility, and she didn't care what was in them or what she was going to do with them, but she was not getting them. She had ordered stuff for her dentures. During an interview with the Administrator, on 3/29/23 at 9:23 a.m., she indicated she did have a package for Resident D, and they were not going to allow her to have any packages in her room and keep them in there. She did not know what was in		been being held due to severe hoarding. No other packages were being withheld. · *No other residents have had their packages withheld. · *Administrator will ensure that all residents receive their packages. Hoarders that are identified will be given proper notice regarding lease agreement and steps will be followed that do not conflict with Resident Rights. · *Staff will be inserviced on ensuring package deliveries will be readily available or delivered. · *Compliance date is 4/21	

	the package she was holding. She had told the resident she could have her packages with medication in them. She was a hoarder, it was pretty bad. They had several residents who were hoarders, and they had been allowed to live a certain way. They had been inspecting these resident's rooms weekly, and most of the resident's rooms were improving. The resident had pet birds in her apartment, and they were undeclared. Pets had to be a service animal or an emotional companion. The first time she had entered into her apartment, the state of the bird cage was poor. She had spoken to the resident's family about the state of her apartment and the multiple boxes coming to the facility weekly. After she spoke to the family member, the packages ceased. The Administrator had one package she had held from her for a month or five weeks, which was the only package being held. During an interview with the Administrator, on 3/29/23 at 9:35 a.m., she indicated there were two additional boxes for Resident D in the receptionist area. She now had two boxes and two packages for her. She was not sure when they had arrived at the facility. During an interview with the Administrator, on 3/29/23 at 11:47 a.m., she indicated that			

	receptionist received the packages yesterday or the day before. During an interview with the Receptionist, on 3/29/23 at 12:01 p.m., she indicated she had been told by the Administrator not to give Resident D her packages due to the condition of her apartment, as there was no place to put them. She didn't feel like it was being disrespectful, there was just nowhere to put the boxes in her apartment. The packages she just received had been placed in the receptionist area. During an interview with Resident D, on 3/29/23 at 1:37 p.m., she indicated when she got boxes, she broke them down and sat them out for the trash. If they would have asked her to take the product out of the box and give them the box back, she would have. A current facility policy, titled "Sweet Galilee at the Wigwam Initial Lease," revised on 8/28/20 and left on the table in the conference room on 3/29/23 at 1:49 p.m., indicated the following: "...27. Privacy in written communications, including the right to send and promptly receive mail unopened, unless the resident otherwise instructs in writing...." Based on interview and record			

	review, the facility failed to ensure a resident received her mail promptly for 1 of 1 resident reviewed for mail delivery (Resident D). Findings include: During an interview with Resident D, on 3/28/23 at 12:40 p.m., she indicated she admitted she had a lot of stuff in her apartment. The Administrator had told her she had the resident's packages, which were delivered to the facility, and she didn't care what was in them or what she was going to do with them, but she was not getting them. She had ordered stuff for her dentures. During an interview with the Administrator, on 3/29/23 at 9:23 a.m., she indicated she did have a package for Resident D, and they were not going to allow her to have any packages in her room and keep them in there. She did not know what was in the package she was holding. She had told the resident she could have her packages with medication in them. She was a hoarder, it was pretty bad. They had several residents who were hoarders, and they had been allowed to live a certain way. They had been inspecting these resident's rooms weekly, and most of the resident's rooms were improving. The resident had pet birds in her apartment,			

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R 0406	Infection Control - Offense 410 IAC 16.2-5-12(a) (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation, interview, and record review, the	R 0406	· *All residents had the potential to be affected by this deficient practice. All residents were told to put down the chicken and not eat it, immediately upon identification of an undercooked piece of chicken. · *The Administrator and Dietary Manager went to	04/21/2023

	facility failed to ensure chicken was cooked thoroughly to proper temperature prior to being served to residents to prevent potential infectious illness. This deficient practice had the potential to effect 76 of 76 residents residing at the facility. Findings include: Review of the lunch menu for 3/22/23 indicated fried chicken, mashed potatoes, chicken gravy, green beans, fresh baked bread, key lime cake, margarine, and coffee/tea. During an interview with the Dietary Manager, on 3/28/23 at 9:05 a.m., she indicated there was a miscommunication at lunch on 3/22/23. Cook 6 came into work at 6:00 a.m. and Cook 4 came in at 11:00 a.m. Cook 6 dropped the chicken in the fryer, pulled it up from the fryer before the cooking time was completed, and went to break without communicating with Cook 4. When Cook 4 came in, she thought the chicken was done and had served it without first checking the temperature. Cook 6 had planned to drop the chicken again when he came back from his break. He didn't know Cook 4 hadn't resumed cooking the chicken before serving it. During an interview with		each resident and inspected each piece of chicken. Undercooked pieces were taken away and replaced with fully cooked/temped pieces. · *All Cooks were given immediate re education of proper temping policy and procedure and disciplinary follow-up of identified staff member by the Culinary Manager. · *Culinary Manager or designee will temp all meats prior to being served, five times per week for 3 months, then once per week for 1 month. Temp logs and audit forms to be brought to monthly QA meeting · *Compliance date is 4/21	

Resident B, on 3/28/23 at 9:20 a.m., she indicated the chicken leg she had been served looked like it was cooked on the outside, but the inside was red. She had already taken some bites off it before she noticed.

During an interview with Resident D, on 3/28/23 at 9:40 a.m., she indicated she had been served an undercooked chicken quarter. She went to take a bite and noticed it was undercooked.

During an interview with Resident E, on 3/28/23 at 9:46 a.m., she indicated her chicken was pink on the inside but looked cooked on the outside.

During an interview with Resident F, on 3/28/23 at 9:51 a.m., he indicated he had a leg and a thigh, which looked like it was cooked on the outside, but the inside was bloody. He had eaten half of it.

During an interview with Resident C, on 3/28/23 at 9:58 a.m., he indicated another resident had made an announcement to make everyone stop eating the chicken during the meal. His chicken was raw and bloody, but the outside of it looked like it had been cooked.

During an interview with Resident G, on 3/28/23 at 10:01 a.m., she indicated she had the

dark meat chicken and everything was fine until she gotten to the bone, and it was bloody. She had already eaten a good bit of the chicken. She had diarrhea later, which lasted for the day. She was worried about "stomach poisoning".

During an interview with Resident H, on 3/28/23 at 10:08 a.m., she indicated she had been served a breast, and it was ok. The chicken the other residents had at her table was bloody and raw. The outside of the chicken was pretty, and crispy brown. One resident, who was blind, had asked her if her chicken was done while she was eating it. She had told her no and to put it down. A family member had cut open another resident's chicken, and it was pink and raw on the inside.

During an interview with Cook 6, on 3/28/23 at 10:12 a.m., he indicated that it was a miscommunication between himself and Cook 4. He had already cooked two pans of chicken and they were ready to be served. He dropped some chicken in the fryer and noticed it was time for his break. He pulled the baskets up from the fryer and told Cook 4 that he was going to break and the chicken pieces needed to be put back down in the fryer. He didn't think she heard him, and she had served the uncooked

	chicken to the residents. When he came back from his 30 minute break, they had brought the chicken back to him and told him that it was reddish looking. He didn't think anyone had eaten it. They were big quarter pieces of chicken. There were about 14 pieces of chicken, which were not cooked all the way. They collected all the undercooked chicken, and they floured and fried new chicken. During an interview with Resident J, on 3/28/23 at 11:08 a.m., she indicated the Administrator yelled to everyone in the dining room not to eat the chicken. She had eaten her chicken already, as she didn't know it was undercooked, since she was blind. She had diarrhea, just for the day, until it got out of her system. She didn't want to eat the chicken from the facility anymore.			

During an interview with Cook 4, on 3/28/23 at 2:46 p.m., she indicated it had been a big misunderstanding. She had taken over and served lunch at 11:00 a.m. Cook 6 had dropped the chicken in the fryer and pulled it out. She didn't know it was not ready or was not done. She should had taken the temperature of the chicken before she served it. The chicken looked delicious and done, but you couldn't go off looks.

During an interview with the Administrator, on 3/29/23 at 9:23 a.m., she indicated she was in her office when the receptionist told her that a family member was loud and upset at the desk because there was undercooked chicken served to the residents. She went to the dining room. Herself and the Dietary Manager went around to the tables - most residents had not bitten into the chicken, and she had the aides go to the resident's rooms and collect their plates. There was a total of four pieces of breast meat found to be undercooked.

A current, undated facility policy, titled "Cooking Potentially Hazardous Foods Policy and Procedure," left on the conference room table on 3/29/23 at 1:49 p.m., indicated the following: "...Procedure: The purpose of this policy is to

ensure that all food products are cooked to the proper temperature. Policy...to cook foods to proper internal temperature...Raw animals foods, such as, poultry...shall be cooked to heat all parts of the food to the following temperatures and times. 1) 145 degrees Fahrenheit (63 degrees Celsius) or above for 15 seconds...."

This state residential finding relates to complaint IN00404895.

Based on observation, interview, and record review, the facility failed to ensure chicken was cooked thoroughly to proper temperature prior to being served to residents to prevent potential infectious illness. This deficient practice had the potential to effect 76 of 76 residents residing at the facility.

Findings include:

Review of the lunch menu for 3/22/23 indicated fried chicken, mashed potatoes, chicken gravy, green beans, fresh baked bread, key lime cake, margarine, and coffee/tea.

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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