STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/02/2025

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 a State Residential Licensure Survey. Survey dates: July 1 and 2, 2025 Facility number: 014706 Residential Census: 91 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed July 8, 2025.	R 0000		
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on	R 0117	All residents had the potential to be affected by this deficient practice. The Director of Nursing will be in-serviced by the Executive Director on the regulation. Sweet Galilee will	08/15/2025

	skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure a staff member with first aid and cardiopulmonary resuscitation (CPR) certification was scheduled for 8 of 21 shifts reviewed. This deficiency had to the potential to affect 91 of 91 residents residing in the facility. Findings include: Employee schedules, provided by the Administrator on 7/1/25 at 1:00 p.m., were reviewed on 7/1/25 at 2:37 p.m., and indicated the following shifts lacked a staff member certified in first aid and CPR:		offer free CPR/First Aid classes to all employees to ensure compliance of the regulation. The DON or designee will audit the employee work schedules Daily X's 1-month, weekly times 4 weeks and monthly for 6 months to ensure compliance for the regulation. Variances will be immediately corrected and audits will be reported to the Quality Assurance Committee. QAPI committee will review audit for 6 months.	

	6/22/25 from 11:00 p.m. - 7:00 a.m., 6/23/25 from 11:00 p.m. - 7:00 a.m., 6/24/25 from 11:00 p.m. - 7:00 a.m., 6/25/25 from 5:30 p.m.- 11:00 p.m. and 11:00 p.m. - 7:00 a.m., 6/26/25 from 11:00 p.m. - 7:00 p.m., 6/27/25 from 5:30 p.m. - 11:00 p.m. and 11:00 p.m. - 7:00 a.m., 6/28/25 from 11:00 p.m. - 7:00 a.m. During an interview, on 7/2/25 at 12:45 p.m., the DON indicated the schedule was completed by herself and the Administrator and at least one staff member needed to have certifications in both first aid and CPR. She instructed staff to complete the online portions of the CPR training and was making attempts to get an in-person instructor to come to the facility. She was working on getting CPR and first aid training completed annually at the facility for all staff members.			

During an interview, on 7/2/25 at 1:09 p.m., the Administrator indicated the DON was responsible to ensure there was a staff member certified in first aid and CPR on all shifts.

A facility policy, effective 2/24, titled, "CPR & First Aid Certifications", provided by the Administrator on 7/2/25 at 12:27 p.m., indicated the following: "... All clinical staff will maintain current CPR & First Aid certification and have re-certification upon expiration...D. It is the responsibility of the Director of Nursing to ensure at least one employee with current CPR & First Aid Certifications is on duty at all times."

Based on record review and interview, the facility failed to ensure a staff member with first aid and cardiopulmonary resuscitation (CPR) certification was scheduled for 8 of 21 shifts reviewed. This deficiency had to the potential to affect 91 of 91 residents residing in the facility.

Findings include:

Employee schedules, provided by the Administrator on 7/1/25 at 1:00 p.m., were reviewed on 7/1/25 at 2:37 p.m., and indicated the following shifts lacked a staff member certified in first aid and CPR:

6/22/25 from 11:00 p.m. - 7:00

	a.m., 6/23/25 from 11:00 p.m. - 7:00 a.m., 6/24/25 from 11:00 p.m. - 7:00 a.m., 6/25/25 from 5:30 p.m.- 11:00 p.m. and 11:00 p.m. - 7:00 a.m., 6/26/25 from 11:00 p.m. - 7:00 p.m., 6/27/25 from 5:30 p.m. - 11:00 p.m. and 11:00 p.m. - 7:00 a.m., 6/28/25 from 11:00 p.m. - 7:00 a.m. During an interview, on 7/2/25 at 12:45 p.m., the DON indicated the schedule was completed by herself and the Administrator and at least one staff member needed to have certifications in both first aid and CPR. She instructed staff to complete the online portions of the CPR training and was making attempts to get an in-person instructor to come to the facility. She was working on getting CPR and first aid training completed annually at the facility for all staff members. During an interview, on 7/2/25 at 1:09 p.m., the Administrator indicated the DON was responsible to ensure there was a staff member certified in first aid and CPR on all shifts.			

	A facility policy, effective 2/24, titled, "CPR & First Aid Certifications", provided by the Administrator on 7/2/25 at 12:27 p.m., indicated the following: "... All clinical staff will maintain current CPR & First Aid certification and have re-certification upon expiration...D. It is the responsibility of the Director of Nursing to ensure at least one employee with current CPR & First Aid Certifications is on duty at all times."			
R 0118	Personnel - Deficiency 410 IAC 16.2-5-1.4(c) (c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide.	R 0118	All residents had the potential to be affected by this deficient practice. The Business Office Manager will be inserviced on the regulation by the Executive Director. The Home Health Aide was immediately suspended until the certification was recertified. An audit of employees that require license or certification has been completed by the Business Office Director. The Business office	08/15/2025

	Based on record review and interview, the facility failed to ensure a Home Health Aide (HHA) did not provide resident care with an expired certification for 1 of 24 employees reviewed for active certifications and licensure. Finding includes: Employee record review, completed 7/1/25 at 2:37 p.m., indicated HHA 9's Home Health Aide certification was expired on 5/25/25. Employee schedules, provided by the Administrator on 7/1/25 at 1:00 p.m., were reviewed on 7/1/25 at 2:37 p.m. indicated HHA 9 worked the following shifts: On 5/26/25 from 3:00 p.m. - 11:00 p.m., 5/27/25 from 3:00 p.m. - 11:00 p.m., 5/28/25 from 3:00 p.m. - 11:00 p.m., 5/29/25 from 3:00 p.m. - 11:00 p.m., 5/31/25 from 3:00 p.m. - 11:00 p.m., 6/3/24 from 3:00 p.m. - 11:00 p.m.,		Director/Designee will audit employee certifications/licenses monthly times 6 months to ensure compliance of the regulation. Variances will be corrected immediately and audits will be reported to the Quality Assurance Committee. Findings will be reported to the Quality Assurance Committee. QAPI committee will review the audit for 6 months	

	6/4/24 from 3:00 p.m. - 11:00 p.m., 6/5/25 from 3:00 p.m. - 11:00 p.m., 6/7/25 from 3:00 p.m. - 11:00 p.m., 6/8/25 from 3:00 p.m. - 11:00 p.m., 6/9/25 from 3:00 p.m. - 11:00 p.m., 6/10/25 from 3:00 p.m. - 11:00 p.m., 6/11/25 from 3:00 p.m. - 11:00 p.m., 6/12/25 from 3:00 p.m. - 11:00 p.m., 6/13/25 from 3:00 p.m. - 11:00 p.m., 6/17/25 from 3:00 p.m. - 11:00 p.m., 6/18/25 from 3:00 p.m. - 11:00 p.m., 6/19/25 from 3:00 p.m. - 11:00 p.m., 6/21/25 from 3:00 p.m. - 11:00 p.m., 6/22/25 from 3:00 p.m. - 11:00 p.m., 6/23/25 from 3:00 p.m. - 11:00 p.m.,			

	6/24/25 from 3:00 p.m. - 11:00 p.m., 6/25/25 from 3:00 p.m. - 11:00 p.m., 6/26/25 from 3:00 p.m. - 11:00 p.m., 6/27/25 from 3:00 p.m. - 11:00 p.m.. During an interview, on 7/2/25 at 12:45 p.m., the DON indicated it was up to the staff to ensure their licensure or certifications were current and up to date. An employee with an expired license would not be eligible to work and would not be scheduled. During an interview, on 7/2/24 at 1:09 p.m., the Administrator indicated staff members were responsible for ensuring their licenses and certifications were renewed on time. She and the Business Office Manager (BOM) tried to keep track of licensures and reminded the staff to renew them. A facility policy, effective 1/22, titled, "Personnel Records", provided by the Administrator on 7/2/25 at 1:25 p.m., indicated the following: "... E. All employees are responsible for notifying the community of any change in personal information to include name, address, telephone number, licensure, and health status. This is			

	needed to assure continuity in benefits and to fulfill other informational needs for both the community and employee...E. The following documents will be retained in the personnel file or separate file as appropriate...8. License, copy and as updated (if applicable)..." Based on record review and interview, the facility failed to ensure a Home Health Aide (HHA) did not provide resident care with an expired certification for 1 of 24 employees reviewed for active certifications and licensure. Finding includes: Employee record review, completed 7/1/25 at 2:37 p.m., indicated HHA 9's Home Health Aide certification was expired on 5/25/25. Employee schedules, provided by the Administrator on 7/1/25 at 1:00 p.m., were reviewed on 7/1/25 at 2:37 p.m. indicated HHA 9 worked the following shifts: On 5/26/25 from 3:00 p.m. - 11:00 p.m., 5/27/25 from 3:00 p.m. - 11:00 p.m., 5/28/25 from 3:00 p.m. - 11:00 p.m., 5/29/25 from 3:00 p.m. - 11:00			

	p.m., 5/31/25 from 3:00 p.m. - 11:00 p.m., 6/3/24 from 3:00 p.m. - 11:00 p.m., 6/4/24 from 3:00 p.m. - 11:00 p.m., 6/5/25 from 3:00 p.m. - 11:00 p.m., 6/7/25 from 3:00 p.m. - 11:00 p.m., 6/8/25 from 3:00 p.m. - 11:00 p.m., 6/9/25 from 3:00 p.m. - 11:00 p.m., 6/10/25 from 3:00 p.m. - 11:00 p.m., 6/11/25 from 3:00 p.m. - 11:00 p.m., 6/12/25 from 3:00 p.m. - 11:00 p.m., 6/13/25 from 3:00 p.m. - 11:00 p.m., 6/17/25 from 3:00 p.m. - 11:00 p.m., 6/18/25 from 3:00 p.m. - 11:00 p.m., 6/19/25 from 3:00 p.m. - 11:00 p.m., 6/21/25 from 3:00 p.m. - 11:00			

	p.m., 6/22/25 from 3:00 p.m. - 11:00 p.m., 6/23/25 from 3:00 p.m. - 11:00 p.m., 6/24/25 from 3:00 p.m. - 11:00 p.m., 6/25/25 from 3:00 p.m. - 11:00 p.m., 6/26/25 from 3:00 p.m. - 11:00 p.m., 6/27/25 from 3:00 p.m. - 11:00 p.m.. During an interview, on 7/2/25 at 12:45 p.m., the DON indicated it was up to the staff to ensure their licensure or certifications were current and up to date. An employee with an expired license would not be eligible to work and would not be scheduled. During an interview, on 7/2/24 at 1:09 p.m., the Administrator indicated staff members were responsible for ensuring their licenses and certifications were renewed on time. She and the Business Office Manager (BOM) tried to keep track of licensures and reminded the staff to renew them. A facility policy, effective 1/22, titled, "Personnel Records", provided by the Administrator on			

	7/2/25 at 1:25 p.m., indicated the following: "... E. All employees are responsible for notifying the community of any change in personal information to include name, address, telephone number, licensure, and health status. This is needed to assure continuity in benefits and to fulfill other informational needs for both the community and employee...E. The following documents will be retained in the personnel file or separate file as appropriate...8. License, copy and as updated (if applicable)..."			
R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3) (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4)	R 0120	All residents had the potential to be affected by this deficient practice. The Business Office Manager will be inserviced on the regulation by the Executive Director. An audit of employee files has been completed by Business Office Manager. All employees who were identified in the audit have been assigned the required training through an approved education program. The required in-service training will be completed by the Date of	08/15/2025

	hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.		Compliance. An audit of staff training will be completed by the Business Office Manager/Designee weekly times 4 weeks and monthly times 6 months. Staff who do not complete the assigned training will be removed from the schedule until completion. Any variances identified will be corrected and findings will be reported to the Quality Assurance Committee. QAPI committee will review the audit for 6 months.	

	A. Based on record review and interview, the facility failed to ensure employees, who had been employed for greater than one year, had three (3) hours of annual dementia training, resident rights training, and abuse training for 1 of 3 employees reviewed for annual training. (Qualified Medication Aide (QMA) 7) B. Based on record review and interview, the facility failed to ensure newly hired employees had 6 hours of dementia training within 6 months, resident rights training, and abuse training for 2 of 2 employees reviewed for new hire training. (Qualified Medication Aide (QMA) 5 and Certified Nursing Assistant (CNA) 8) Findings include: A. Employee record review, completed 7/1/25 at 2:37 p.m., indicated QMA 7, hire date 9/21/22, lacked documentation for three hours annual dementia training, resident rights training, and abuse training completed in the last calendar year. B. Employee record review, completed 7/1/25 at 2:37 p.m., indicated CNA 8, hire date 1/13/25, and QMA 5, hire date 12/9/24, lacked documentation for new hire resident rights training, abuse training, and six hours of dementia training			

completed within six months.

During an interview, on 7/2/25 at 1:09 p.m., the Administrator indicated the employees were responsible for completing all the necessary training. The Business Office Manager (BOM) was the staff member responsible for keeping the employee records complete and up to date. She and the BOM sent out reminder messages to staff asking them to complete required paperwork and any training needed. She indicated there was no additional employee record documentation to be provided.

A facility policy, effective 6/21, titled, "Staff Training Policy and Procedures", provided by the Administrator on 7/2/25 at 1:25 p.m., indicated the following: "... A. It is the responsibility of the Administrator or designee to complete orientation and training with all staff members within 30 days of employment...C. It is the responsibility of the Administrator or designee to remove employees from the work schedule if they fail to attend orientation, in-service meetings, or completed Learning Management courses... A. Within 30 days of employment, all staff members will complete orientation and training to the community and their assigned department and

	area of responsibility. Training and education continues on a semi-annual basis and more often when appropriate. Training topics will include, but not limited to: Resident Rights...Prevention and notification of abuse, neglect, and financial exploitation...Techinques for working with persons with disabilities and the elderly populations... C. Training is also offered and assigned on our Relias Learning Software. Due dates are issued for the Relias course and it's mandatory that all employees maintain completion and compliance with their module/course assignments. D. Employees who fail to attend orientation, in-service training, and maintain completion/compliance of their Relias courses may be removed from the work schedule until requirements are completed..." A facility policy, effective 1/22, titled, "Personnel Records", provided by the Administrator on 7/2/25 at 1:25 p.m., indicated the following: "... D. It is the responsibility of all Department Heads/Supervisors to make sure all original copies of the evaluations, disciplinary actions, termination, and other related documentation is promptly placed in the Employee's personnel file in a timely manner...E. The following documents will be retained in			

	the personnel file or separate file as appropriate:...10. Patient abuse statement (signed)..." A. Based on record review and interview, the facility failed to ensure employees, who had been employed for greater than one year, had three (3) hours of annual dementia training, resident rights training, and abuse training for 1 of 3 employees reviewed for annual training. (Qualified Medication Aide (QMA) 7) B. Based on record review and interview, the facility failed to ensure newly hired employees had 6 hours of dementia training within 6 months, resident rights training, and abuse training for 2 of 2 employees reviewed for new hire training. (Qualified Medication Aide (QMA) 5 and Certified Nursing Assistant (CNA) 8) Findings include: A. Employee record review, completed 7/1/25 at 2:37 p.m., indicated QMA 7, hire date 9/21/22, lacked documentation for three hours annual dementia training, resident rights training, and abuse training completed in the last calendar year. B. Employee record review, completed 7/1/25 at 2:37 p.m., indicated CNA 8, hire date 1/13/25, and QMA 5, hire date 12/9/24, lacked documentation			

	for new hire resident rights training, abuse training, and six hours of dementia training completed within six months. During an interview, on 7/2/25 at 1:09 p.m., the Administrator indicated the employees were responsible for completing all the necessary training. The Business Office Manager (BOM) was the staff member responsible for keeping the employee records complete and up to date. She and the BOM sent out reminder messages to staff asking them to complete required paperwork and any training needed. She indicated there was no additional employee record documentation to be provided. A facility policy, effective 6/21, titled, "Staff Training Policy and Procedures", provided by the Administrator on 7/2/25 at 1:25 p.m., indicated the following: "... A. It is the responsibility of the Administrator or designee to complete orientation and training with all staff members within 30 days of employment...C. It is the responsibility of the Administrator or designee to remove employees from the work schedule if they fail to attend orientation, in-service meetings, or completed Learning Management courses... A. Within 30 days of employment, all staff members			

	will complete orientation and training to the community and their assigned department and area of responsibility. Training and education continues on a semi-annual basis and more often when appropriate. Training topics will include, but not limited to: Resident Rights...Prevention and notification of abuse, neglect, and financial exploitation...Techinques for working with persons with disabilities and the elderly populations... C. Training is also offered and assigned on our Relias Learning Software. Due dates are issued for the Relias course and it's mandatory that all employees maintain completion and compliance with their module/course assignments. D. Employees who fail to attend orientation, in-service training, and maintain completion/compliance of their Relias courses may be removed from the work schedule until requirements are completed..." A facility policy, effective 1/22, titled, "Personnel Records", provided by the Administrator on 7/2/25 at 1:25 p.m., indicated the following: "... D. It is the responsibility of all Department Heads/Supervisors to make sure all original copies of the evaluations, disciplinary actions, termination, and other related documentation is promptly placed in the Employee's			

	personnel file in a timely manner...E. The following documents will be retained in the personnel file or separate file as appropriate:...10. Patient abuse statement (signed)..."			
R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.	R 0121	All residents had the potential to be affected by this deficient practice. The Director of Nursing will be in-service on the regulation by the Executive Director. An audit of employee files was completed by Business Office Manager. All missing health screens and TB tests have been completed. The Director of Nursing/Designee audit of staff training will be completed weekly times 4 weeks and monthly times 6 months. Variances will be corrected at the time of finding. Audit results will be presented to the **Quality Assurance and Performance Improvement**	08/15/2025

	(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the facility failed to ensure employees were screened for tuberculosis (TB) and/or obtained completed health screenings upon hire for 2 of 3 newly hired employees (Qualified Medication Aide (QMA), Dietary Aide 6, and Certified Nurse Aide (CNA) 8). Finding includes: Employee record review, completed 7/1/25 at 2:37 p.m., indicated CNA 8, hire date 1/13/25, lacked documentation of a health screen and a two (2) step TB test and QMA 6, hire date 3/31/25, lacked documentation of a health screen.		**(QAPI) Committee** monthly for **6 months**.	

	During an interview, on 7/2/25 at 1:09 p.m., the Administrator indicated the Business Office Manager (BOM) was the staff member responsible for keeping the employee records complete and up to date. She and the BOM sent out reminder messages to staff asking them to complete required paperwork. She indicated there was no additional employee record documentation to be provided. A facility policy, effective 1/22, titled, "Personnel Records", provided by the Administrator on 7/2/25 at 1:25 p.m., indicated the following: "... D. It is the responsibility of all Department Heads/Supervisors to make sure all original copies of the evaluations, disciplinary actions, termination, and other related documentation is promptly placed in the Employee's personnel file in a timely manner...E. The following documents will be retained in the personnel file or separate file as appropriate:...3. Orientation checklist, 4. TB testing results..." Based on record review and interview, the facility failed to ensure employees were screened for tuberculosis (TB) and/or obtained completed health screenings upon hire for 2 of 3 newly hired employees (Qualified Medication Aide (QMA), Dietary Aide 6, and			

	Certified Nurse Aide (CNA) 8). Finding includes: Employee record review, completed 7/1/25 at 2:37 p.m., indicated CNA 8, hire date 1/13/25, lacked documentation of a health screen and a two (2) step TB test and QMA 6, hire date 3/31/25, lacked documentation of a health screen. During an interview, on 7/2/25 at 1:09 p.m., the Administrator indicated the Business Office Manager (BOM) was the staff member responsible for keeping the employee records complete and up to date. She and the BOM sent out reminder messages to staff asking them to complete required paperwork. She indicated there was no additional employee record documentation to be provided. A facility policy, effective 1/22, titled, "Personnel Records", provided by the Administrator on 7/2/25 at 1:25 p.m., indicated the following: "... D. It is the responsibility of all Department Heads/Supervisors to make sure all original copies of the evaluations, disciplinary actions, termination, and other related documentation is promptly placed in the Employee's personnel file in a timely manner...E. The following documents will be retained in			

	the personnel file or separate file as appropriate:...3. Orientation checklist, 4. TB testing results..."			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure food was prepared and served under safe sanitary conditions. This deficient practice had the potential to impact 91 of 91 residents who received meals from the kitchen. Findings include: During a lunch meal observation on 7/1/25 from 11:06 a.m. to 11:17 a.m. following concerns regarding food preparation and handling were observed: Cook 4 was wearing single use disposable dietary gloves on both hands. Using her gloved hands, she touched paper meal tickets, which had been circulated and completed in the main dining room and returned	R 0273	All Residents have the potential to be affected by this deficiency. The Executive Director will provide in-service training to the Dietary Manager on proper safe food handling regulations. The Dietary Manager will conduct in-service training for dietary staff on proper safe food handling practices. The Dietary Manger will audit meal service for proper safe food handling practices 3 times a week for 8 weeks, 1 time a week for 4 months. The QAPI Committee will review the results of these audits monthly for 6 months. Variances will be corrected at the time of observation, and findings will be reviewed by the community’s QAPI committee monthly for 6 months.	08/15/2025

to the kitchen. She then touched the outside of a bread bag, the tie/fastener on the bed bag, reached inside and removed slices on bread, she then open the refrigerated unit located under the food preparation area and removed a wrapped block of cheese and placed in the food preparation area all with her contaminated gloves. She removed her gloves and reapplied new gloved without hand washing.

Cook 4, using her new gloves, picked up more meal tickets and placed them on the holder. She then removed a slice of bread from the bread bag. She touched the bread with her contaminated gloved hands. She placed the slice of bread flat on the palm of her gloved hand. She spread butter using a pastry brush. She then used her contaminated gloved hand to place the bread slice on the grill. She repeated this process with a second slice of bread.

Wearing the same contaminated gloves, she open the chest freezer and removed a food item. She went to the deep fryer, poured the food in the fryer. Using the same gloved hands, she held the fryer basket handle and lowered the food into the hot oil.

Cook 4 then removed her gloves and went to the walk in

freezer. She returned carrying two new gloves and hotdogs wrapped in a plastic wrap. She put on the gloves she was carrying. She did not wash her hands prior to putting on the gloves. Using her gloved hands she placed two hot dogs on the grill surface.

While wearing the same contaminated gloves, she unwrapped the cheese and carried 2 slices of cheese over to the grill. She then placed the cheese on the buttered bread that was toasting on the grill. She then took off her gloves and applied new gloves without washing her hands.

Wearing the new gloves, she went to the chest cooler and opened the cooler, touching the handle with her gloved hands. She removed a food item. She then touched the fryer handle with her gloved hands. She then returned to the chest cooler touching the handle with her glover hands. She picked up a Styrofoam food container opened it making contact with the interior food contact surface.

She then used tongs to remove hot food from the fryer basket. She stepped over to the grill and flipped a grilled cheese. As she turned the grilled cheese, she touched the top slice of toasted bread with her contaminated gloved hand. She

repeated this process and a second grilled cheese sandwich. She then touched a water praying device, with her same contaminated gloved hands and spayed water on the hotdogs, which were on the grill. She touched a knob on the stove. She then touched meal tickets, tongs, scoops, and plates.

She went to the grill removed the grill cheese touching them with her contaminated glove hands and using her hands and a spatula placed them in a S,Styrofoam food container. She then touched the handles under the food service area.

Using her contaminated gloved hands, she placed a slice of cheese on a burger that was on the grill. She then touched tongs, scoops, meal tickets, and plates with the same contaminated gloved hands.

During an interview on 7/1/25 at 11:14 a.m., Cook 4 indicated there was not a way to do her meal preparation and service without touching food with her gloved hands. She had not considered her gloves being contaminated after touching multiple food items. She did not realize that gloves should only be used to touch one food item then discarded.

During an observation and interview on 7/1/25 at 11:15

a.m., the Dietary Manger used his contaminated gloved hands to remove wrapped sliced cheese from the food preparation area. He then used his contaminated gloved hands to touch the sliced cheese and demonstrate hands were needed to separate the slices. Lastly he stated he didn't realize his hands should be washed, fresh clean gloves applied, and then cheese should be separated using single use gloves. He did not realize that having touched multiple other items with his gloves before touching the cheese, had contaminated the cheese.

A current, undated, facility policy titled, "General Food Preparation Policy and Procedure" , which was provided by the Administrator on 7/1/25 at 1:48 p.m., indicated: "...Handling ready-to-eat food only with suitable utensils such as deli tissue, spatulas, tongs, or single-use gloves.... shall be preceded by thorough hand washing. If gloves are used to handle ready-to-eat food, they shall be single use gloves...."

Based on observation, interview, and record review, the facility failed to ensure food was prepared and served under safe sanitary conditions. This deficient practice had the potential to impact 91 of 91 residents who received meals

from the kitchen.

Findings include:

During a lunch meal observation on 7/1/25 from 11:06 a.m. to 11:17 a.m. following concerns regarding food preparation and handling were observed:

Cook 4 was wearing single use disposable dietary gloves on both hands. Using her gloved hands, she touched paper meal tickets, which had been circulated and completed in the main dining room and returned to the kitchen. She then touched the outside of a bread bag, the tie/fastener on the bed bag, reached inside and removed slices on bread, she then open the refrigerated unit located under the food preparation area and removed a wrapped block of cheese and placed in the food preparation area all with her contaminated gloves. She removed her gloves and reapplied new gloved without hand washing.

Cook 4, using her new gloves, picked up more meal tickets and placed them on the holder. She then removed a slice of bread from the bread bag. She touched the bread with her contaminated gloved hands. She placed the slice of bread flat on the palm of her gloved hand. She spread butter using a pastry brush. She then used her

contaminated gloved hand to place the bread slice on the grill. She repeated this process with a second slice of bread.

Wearing the same contaminated gloves, she open the chest freezer and removed a food item. She went to the deep fryer, poured the food in the fryer. Using the same gloved hands, she held the fryer basket handle and lowered the food into the hot oil.

Cook 4 then removed her gloves and went to the walk in freezer. She returned carrying two new gloves and hotdogs wrapped in a plastic wrap. She put on the gloves she was carrying. She did not wash her hands prior to putting on the gloves. Using her gloved hands she placed two hot dogs on the grill surface.

While wearing the same contaminated gloves, she unwrapped the cheese and carried 2 slices of cheese over to the grill. She then placed the cheese on the buttered bread that was toasting on the grill. She then took off her gloves and applied new gloves without washing her hands.

Wearing the new gloves, she went to the chest cooler and opened the cooler, touching the handle with her gloved hands. She removed a food item. She

	then touched the fryer handle with her gloved hands. She then returned to the chest cooler touching the handle with her glover hands. She picked up a Styrofoam food container opened it making contact with the interior food contact surface. She then used tongs to remove hot food from the fryer basket. She stepped over to the grill and flipped a grilled cheese. As she turned the grilled cheese, she touched the top slice of toasted bread with her contaminated gloved hand. She repeated this process and a second grilled cheese sandwich. She then touched a water praying device, with her same contaminated gloved hands and spayed water on the hotdogs, which were on the grill. She touched a knob on the stove. She then touched meal tickets, tongs, scoops, and plates. She went to the grill removed the grill cheese touching them with her contaminated glove hands and using her hands and a spatula placed them in a S,Styrofoam food container. She then touched the handles under the food service area. Using her contaminated gloved hands, she placed a slice of cheese on a burger that was on the grill. She then touched tongs, scoops, meal tickets, and plates with the same			

contaminated gloved hands.

During an interview on 7/1/25 at 11:14 a.m., Cook 4 indicated there was not a way to do her meal preparation and service without touching food with her gloved hands. She had not considered her gloves being contaminated after touching multiple food items. She did not realize that gloves should only be used to touch one food item then discarded.

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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