STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITA OF MARION	4211 S ADAMS STREET, MARION, , 46953

(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 Intake 467557, 467466, 467754. Intake 467557 - State deficiencies related to the allegations are cited at R0051 and R0052. Intake 467466 - No deficiencies related to the allegations are cited. Intake 467754- No deficiencies related to the allegations are cited. Survey dates: February 2, 3, and 4, 2026 Facility number: 015081 Residential Census: 88 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000		

	Quality review completed February 11, 2026.			
R 0030	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(e)(1-6) (e) Residents have the right to be provided, at the time of admission to the facility, the following: (1) A copy of his or her admission agreement. (2) A written notice of the facility ' s basic daily or monthly rates. (3) A written statement of all facility services (including those offered on an as needed basis). (4) Information on related charges, admission, readmission, and discharge policies of the facility. (5) The facility ' s policy on voluntary termination of the admission agreement by the resident, including the disposition of any entrance fees or deposits paid on admission. The admission agreement shall include at least those items provided for in IC 12-10-15-9. (6) If the facility is required to submit an Alzheimer ' s and dementia special care unit disclosure form under IC 12-10-5.5, a copy of the completed Alzheimer ' s and dementia special care unit disclosure form. Based on record review and	R 0030		02/17/2026

	interview, the facility failed to submit the required Alzheimer's and Dementia Special Care Unit Disclosure Form to the appropriate regulatory authority. This deficient practice had the potential to affect 23 of 23 residents residing on the memory care unit. Findings include: During a review of facility licensure and administrative records on 2/2/26 at 3:08 p.m.,the records indicated the facility operated a designated Alzheimer's and dementia special care unit. However, there was no documentation to demonstrate the required disclosure form had been completed, submitted, or approved by the appropriate State authority. During an interview with the DON on 2/3/26 at 2:48 p.m., she indicated she would provide the form via email. At 2:59 p.m., a copy of a (blank) State Form 48896 was sent to the DON via email. At 3:36 p.m., a return email from the DON indicated the facility did not have the form requested.			

	During an interview with the DON on 2/4/26 at 11:00 a.m., she indicated the facility did not complete State Form 48896. At the same time, the Administrator indicated the same. During an interview with the DON on 2/4/26 at 2:14 p.m., she indicated the facility did not have a policy regarding the dementia disclosure. Based on record review and interview, the facility failed to submit the required Alzheimer's and Dementia Special Care Unit Disclosure Form to the appropriate regulatory authority. This deficient practice had the potential to affect 23 of 23 residents residing on the memory care unit. Findings include: During a review of facility licensure and administrative records on 2/2/26 at 3:08 p.m.,the records indicated the facility operated a designated Alzheimer's and dementia special care unit. However, there was no documentation to demonstrate the required disclosure form had been completed, submitted, or approved by the appropriate State authority. During an interview with the DON on 2/3/26 at 2:48 p.m., she indicated she would provide			

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R 0051	Residents' Rights - Offense 410 IAC 16.2-5-1.2(u) (u) Residents have the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident ' s medical symptoms. Based on observation, interview, and record review, the facility failed to ensure residents were free from chemical restraints for staff convenience to manage a resident's behavior expression of wandering and exit-seeking through use of antipsychotic medication without indication or documented	R 0051		02/17/2026

	psychotic behaviors for 1 of 7 residents reviewed. (Resident 68) Findings include: Resident 68's clinical record was reviewed on 2/3/26. Diagnosis included dementia and insomnia. Current orders included Seroquel (antipsychotic) 50 milligrams (mg) once daily at bedtime (start date of 1/22/26) and trazodone (antidepressant) 100 mg once daily at bedtime. An admission wandering risk assessment, dated 1/15/26, indicated Resident 68 was at a high risk of wandering due to his diagnosis of dementia, history of elopement, sundowning, and intermittent confusion. An admission Saint Louis University Mental Status Exam (SLUMS) indicated resident had dementia and was cognitively impaired. A review of an Emergency Room (ER) note, on 1/13/26, indicated Resident 68 was seen for a psychiatric screening. Resident 68 presented to the ER for worsening confusion and dementia symptoms. Resident 68 did not have any personality changes, was not easily angered, nor had any physical aggression or recurrent			

	hallucinations. The ER assessment and plan indicated there was no indication for a psychiatric hospital stay. An undated Psychiatric Nurse Practitioner note indicated, on 1/22/26, the Provider was notified that Resident 68 displayed exit-seeking behaviors, was pulling out screens, had an altercation with another resident, and was hyper-focused on another resident, thinking she was his mother. His behavior was cooperative, his thought process was illogical, and hallucinations were not apparent. The plan was to start Seroquel 50 mg at bedtime and to give one dose as soon as it was available. During an interview, on 2/3/26 at 2:52 p.m., QMA 6 indicated Resident 68 wandered around the unit quite a bit. He did have an infatuation with a female resident who looked like his deceased mother, who passed away six months ago. On 2/3/26 at 2:54 p.m., the Activity Assistant indicated Resident 68 obsesses over a female resident and wandered into other resident rooms. Most of the time, he was easily redirected. He paced and walked around all day. On 2/4/26 at 9:55 a.m., CNA 7 indicated Resident 68 was			

	always touching on a female resident who he felt was his mother. Sometimes he would go into rooms and attempt to take the screens out of the windows. He constantly wandered around the unit. On 2/4/26 at 10:30 a.m., the Dementia Care Director indicated Resident 68 tried to talk with everyone and wandered around the unit. He was recently started on Seroquel. Resident 68 did not display any psychotic behaviors. A current facility policy, dated 5/21, titled "Elopement Risk and Missing Resident Policy," provided by the DON, on 2/3/26 at 2:42 p.m., indicated the following: " ... an elopement is the unauthorized exit of a resident, who lacks the necessary cognitive skills to maintain individual safety, from the community without adequate supervision, or staff awareness ...." Review of a Medication Guide for Seroquel, accessed from the Food and Drug Administration's (FDA) website at https://www.accessdata.fda.gov/drugsatfda_docs/label/2011/020639s055MG.pdf, indicated the following: ..SEROQUEL may cause serious side effects, including 1. Risk of death in the elderly with dementia...What is			

	SEROQUEL? SEROQUEL is a prescription medicine used to treat schizophrenia in people age 13 or older. SEROQUEL is a prescription medicine used to treat bipolar disorder, including: depressive episodes associated with bipolar disorder in adults...manic episodes associated with bipolar I disorder alone or with lithium or divalproex in adults...long-term treatment of bipolar I disorder with lithium or divalproex in adults... SEROQUEL is used to treat manic episodes associated with bipolar I disorder in children ages 10 to 17 years old....Common possible side effects with SEROQUEL include:...drowsiness...sluggishness...." This citation relates to Intake 467557. Based on observation, interview, and record review, the facility failed to ensure residents were free from chemical restraints for staff convenience to manage a resident's behavior expression of wandering and exit-seeking through use of antipsychotic medication without indication or documented psychotic behaviors for 1 of 7 residents reviewed. (Resident 68) Findings include: Resident 68's clinical record			

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	depressive episodes associated with bipolar disorder in adults...manic episodes associated with bipolar I disorder alone or with lithium or divalproex in adults...long-term treatment of bipolar I disorder with lithium or divalproex in adults... SEROQUEL is used to treat manic episodes associated with bipolar I disorder in children ages 10 to 17 years old....Common possible side effects with SEROQUEL include:...drowsiness...sluggishness...." This citation relates to Intake 467557.			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview, and record review, the facility failed to protect a cognitively impaired resident's	R 0052		02/17/2026

	right to be from neglect related to elopement from the facilities locked memory care unit through a broken laundry room door resulting in the resident gaining access outside the facility. (Resident 68) Findings include: Resident 68's clinical record was reviewed on 2/2/26 at 11:04 a.m. Diagnoses included dementia and insomnia. An admission wandering risk assessment, dated 1/15/26, indicated Resident 68 was at a high risk of wandering due to his diagnosis of dementia, history of elopement, sundowning, and intermittent confusion. An admission Saint Louis University Mental Status Exam (SLUMS) indicated resident had dementia and was cognitively impaired. During an interview, on 2/2/26 at 11:55 a.m., the receptionist indicated she was coming from the receptionist's desk headed back toward the resident mailboxes by door six. Resident 68 was seen walking into the facility through door six's vestibule. When she reached for Resident 68, his coat was cold. With the direction he walked into the facility along with his coat being cold, she assumed he entered the building from the			

	outside. The facility's camera footage was reviewed on 2/2/26 at 3:35 p.m. The footage showed, on 1/23/26 at 12:39 p.m., Resident 68 walked around the memory care unit wearing his jacket and baseball cap. At 12:44 p.m., Resident 68 was seen outside entering the facility through door number six. He entered the vestibule and then entered the second set of doors into the building. The receptionist was seen coming down the hallway from the left side. The receptionist saw Resident 68 and escorted him back into the locked memory care unit. During an interview, on 2/2/26 at 2:45 p.m., the Dementia Care Director indicated once Resident 68 was brought back into the locked memory care unit, she advised staff to make sure all residents were accounted for and immediately went around to see how Resident 68 exited the locked memory care unit. She noticed the laundry door's latch plate was broken, allowing the door to be pushed open if pressure was applied. Maintenance was informed immediately and fixed the broken latch plate. The laundry door did not have a key card reader. It locked and unlocked with a physical key. Resident 68 paced and did laps			

	around the locked memory care unit daily. He wandered into other resident rooms and exit seeked. On 2/2/26 at 4:13 p.m., with Maintenance and the Dementia Care Director present, additional camera footage was reviewed. The camera footage indicated, on 1/23/26 at 12:42 p.m., Resident 68 was walking around the memory care unit's North Dining Room. The laundry room door was not within view of the camera. Camera footage was changed to view the hallway on the backside of the laundry room. At 12:43 p.m., Resident 68 was seen exiting the back door of the laundry room, he turned to his right and exited the facility through the exit door. There was no outside camera footage available to review. Review of a 1/23/26 facility reported incident indicated, on 1/23/26 at approximately 12:42 p.m., Resident 68 was found in door six's vestibule entering the facility. He was assisted back into the locked memory care unit by the receptionist. Review of weather information for 1/23/26 at 12:00 p.m. for Marion, Indiana retrieved from https://www.localconditions.com/weather-marion-indiana/46952/past.php#google_vignette indicated the temperature was 7			

	degrees Fahrenheit (F), with a feel like temperature of -12 degrees F. A current facility policy, dated 5/21, titled "Elopement Risk and Missing Resident Policy," provided by the DON, on 2/3/26 at 2:42 p.m., indicated the following: " ... an elopement is the unauthorized exit of a resident, who lacks the necessary cognitive skills to maintain individual safety, from the community without adequate supervision, or staff awareness ...." This citation relates to Intake 467557. Based on observation, interview, and record review, the facility failed to protect a cognitively impaired resident's right to be from neglect related to elopement from the facilities locked memory care unit through a broken laundry room door resulting in the resident gaining access outside the facility. (Resident 68) Findings include: Resident 68's clinical record was reviewed on 2/2/26 at 11:04 a.m. Diagnoses included dementia and insomnia. An admission wandering risk assessment, dated 1/15/26, indicated Resident 68 was at a			

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	This citation relates to Intake 467557.			
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 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 interview and record review, the facility failed to ensure a certified	R 0117		02/17/2026

	cardiopulmonary resuscitation (CPR) or first-aid certified staff member was on site for seven of forty two shifts reviewed for staffing. Findings include: A review of staffing schedules for the prior seven days, provided by the DON, was completed on 2/3/26 at 9:30 a.m., indicated the following: On 1/24/26, no cardiopulmonary resuscitation (CPR) certified staff were present for second shift. No first aid certified staff was present for second shift. On 1/25/26, no first aid certified staff were present for first or second shift. On 1/27/26, no CPR certified staff were present for the second half of second shift. On 1/28/26, no first aid certified staff were present for the second half of second shift or third shift. During an interview, on 2/4/26 at 10:35 a.m., the DON indicated it was the scheduler's responsibility to make sure there was one staff member certified in CPR and first aid on duty at all times. During an interview, on 2/4/26 at 11:00 a.m., the DON indicated it			

	was ultimately her responsibility to make sure there was always a certified CPR and first aid staff member on duty. There were no other certifications available at that time. A current facility policy, dated 4/24, titled "CPR and First Aid Certifications," provided by the DON, on 2/4/26 at 1:13 p.m., indicated the following: " ...It is the responsibility of the Director of Nursing or designee to ensure at least one on duty has current CPR and first aid certifications at all times ...." Based on interview and record review, the facility failed to ensure a certified cardiopulmonary resuscitation (CPR) or first-aid certified staff member was on site for seven of forty two shifts reviewed for staffing. Findings include: A review of staffing schedules for the prior seven days, provided by the DON, was completed on 2/3/26 at 9:30 a.m., indicated the following: On 1/24/26, no cardiopulmonary resuscitation (CPR) certified staff were present for second shift. No first aid certified staff was present for second shift. On 1/25/26, no first aid certified staff were present for first or			

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R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5)	R 0217		02/17/2026

	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be			

	involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure service plans were signed by residents and/or their legal representatives for 4 of 7 residents reviewed. (Residents 44, 62, 64, and 90.) Findings include: During a review of Resident 44's clinical record on 2/2/26 at 12:18 p.m., a service plan was present, but had not been signed by the resident or the resident's legal representative. During a review of Resident 64's clinical record on 2/3/26 at 9:08 a.m., a service plan was present, but had not been signed by the resident or the resident's legal representative. During a review of Resident 62's clinical record on 2/3/26 at 10:09 a.m., a service plan was present, but had not been signed by the resident or the resident's legal representative. During a review of Resident 90's clinical record on 2/3/26 at 11:01 a.m., a service plan was present, but had not been signed by the resident or the resident's legal representative. All four service plans lacked			

	required signatures to indicate resident participation, review, and agreement with the services to be provided. The clinical records lacked any alternative documentation verifying the residents or their representatives acknowledged and approved the service plans. During an interview with the Dementia Care Director on 2/4/26 at 12:25 p.m., she indicated the service plans should have been signed by the residents and/or by their representatives and were not. A current facility policy, titled "Service Plans", provided by the DON on 2/4/26 at 2:53 p.m., indicated the following: " ...D. Following completion of an evaluation, a licensed nurse in the Community shall identify and document the services to be provided by the Community, as follows ...The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request ...." Based on record review and interview, the facility failed to ensure service plans were signed by residents and/or their legal representatives for 4 of 7 residents reviewed. (Residents 44, 62, 64, and 90.)			

	Findings include: During a review of Resident 44's clinical record on 2/2/26 at 12:18 p.m., a service plan was present, but had not been signed by the resident or the resident's legal representative. During a review of Resident 64's clinical record on 2/3/26 at 9:08 a.m., a service plan was present, but had not been signed by the resident or the resident's legal representative. During a review of Resident 62's clinical record on 2/3/26 at 10:09 a.m., a service plan was present, but had not been signed by the resident or the resident's legal representative. During a review of Resident 90's clinical record on 2/3/26 at 11:01 a.m., a service plan was present, but had not been signed by the resident or the resident's legal representative. All four service plans lacked required signatures to indicate resident participation, review, and agreement with the services to be provided. The clinical records lacked any alternative documentation verifying the residents or their representatives acknowledged and approved the service plans. During an interview with the Dementia Care Director on			

	2/4/26 at 12:25 p.m., she indicated the service plans should have been signed by the residents and/or by their representatives and were not. A current facility policy, titled "Service Plans", provided by the DON on 2/4/26 at 2:53 p.m., indicated the following: " ...D. Following completion of an evaluation, a licensed nurse in the Community shall identify and document the services to be provided by the Community, as follows ...The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request ...."			
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 and interview, the facility failed to maintain the kitchen in a clean and sanitary condition and failed to properly store and label food items. This deficient practice had the potential to affect 88 of 88 residents who received	R 0273		02/17/2026

meals from the facility kitchen.

Findings include:

During an observation on 2/2/26 at 10:40 a.m., accompanied by the Dietary Manager, an uncovered trash can containing coffee grounds and other trash, sat on the floor next to the ice machine.

Three large plastic bins with clear plastic covers were identified to contain flour, sugar, and panko breadcrumbs. Two of the three bins lacked labels with descriptions or open dates. The bin containing the panko breadcrumbs had a label with an open date of 8/7/25. The dietary manager indicated the contents had been replaced on 1/28/26. He did not place a new label on the bin when he refilled it with the breadcrumbs.

A large plastic bin with a clear plastic cover contained oatmeal lacked a label and/or open date. Next to the plastic bin, on a shelf, a large, industrial sized bag of oatmeal containing approximately one fourth of the remaining oatmeal was folded shut at the top. The bag lacked an open date. Next to the opened bag of oatmeal was a large, unopened, industrial sized bag of oatmeal.

A 13-gallon trash can with a "drop-in" lid, designed to close

after contents were placed inside, was too full to close, resulting in trash being exposed to the environment. The trash can was placed near the canned food items. The Dietary Manager indicated he would move the trash can. He did not know why the trash was exposed, except that it needed to be emptied.

On the top of a clean dish rack, clear plastic pitchers were stored upright, allowing for potential contamination.

Large pasta bowls and regular sized soup bowls were stored upright, allowing for potential contamination. The Dietary Manager turned the items upside down, and indicated upright items could gather dust or debris.

At the bottom of the same clean dish rack, two opened cans of lighter fluid were sitting amongst various dish/utensil items. The Dietary Manager indicated the lighter fluid should be stored with other chemicals.

The stove top and griddle grease traps were both covered with aluminum foil, and each contained grease, crumbs, and burnt debris. The Dietary Manager indicated the aluminum foil should be replaced once soiled and the amount of buildup in the grease

traps was not acceptable.

A deep fryer was covered on all visible sides by grease and food splatters. On the floor, on either side of the fryer, were two large cardboard boxes, flattened, and soaked with grease. The Dietary Manager indicated these were used to catch grease from the fryer.

A small serving tray containing condiments was covered with crumbs and debris. The bottom of a bottle of an unidentified liquid, when lifted, had crumbs stuck to the bottom. The Dietary Manager indicated the crumbs could fall into food items when the condiment(s) were in use.

The Dietary Manager indicated there was a cleaning log and he would provide the log after the observation. No cleaning log(s) were located during the observation.

During an interview with the Administrator on 2/4/26 at 10:45 a.m., she indicated the kitchen did not maintain cleaning logs.

A current facility policy, titled "Cleaning Frequency", provided by the DON on 2/4/26 at 3:00 p.m., indicated the following: " ...To provide a clean work environment and insure food safety to our community and staff ...b) To prevent cross-contamination,

kitchenware and food-contact surfaces of equipment shall be washed, rinsed, and sanitized after each use and following any interruption of operations during which time contamination may have occurred ...d) The food-contact surfaces of grills, griddles, and similar cooking devices ....shall be cleaned at least- once a day except that this shall not apply to hot oil cooking equipment and of oil filtering systems. The food-contact surfaces of all cooking equipment shall be kept free of encrusted grease deposits and other accumulated soil ...e) Non-food-contact surfaces of equipment shall be cleaned as often as is necessary to keep the equipment free of accumulation of dust, dirt, food particles, and other debris ...."

Based on observation and interview, the facility failed to maintain the kitchen in a clean and sanitary condition and failed to properly store and label food items. This deficient practice had the potential to affect 88 of 88 residents who received meals from the facility kitchen.

Findings include:

During an observation on 2/2/26 at 10:40 a.m., accompanied by the Dietary Manager, an uncovered trash can containing coffee grounds and other trash,

sat on the floor next to the ice machine.

Three large plastic bins with clear plastic covers were identified to contain flour, sugar, and panko breadcrumbs. Two of the three bins lacked labels with descriptions or open dates. The bin containing the panko breadcrumbs had a label with an open date of 8/7/25. The dietary manager indicated the contents had been replaced on 1/28/26. He did not place a new label on the bin when he refilled it with the breadcrumbs.

A large plastic bin with a clear plastic cover contained oatmeal lacked a label and/or open date. Next to the plastic bin, on a shelf, a large, industrial sized bag of oatmeal containing approximately one fourth of the remaining oatmeal was folded shut at the top. The bag lacked an open date. Next to the opened bag of oatmeal was a large, unopened, industrial sized bag of oatmeal.

A 13-gallon trash can with a "drop-in" lid, designed to close after contents were placed inside, was too full to close, resulting in trash being exposed to the environment. The trash can was placed near the canned food items. The Dietary Manager indicated he would move the trash can. He did not know why the trash was

exposed, except that it needed to be emptied.

On the top of a clean dish rack, clear plastic pitchers were stored upright, allowing for potential contamination.

Large pasta bowls and regular sized soup bowls were stored upright, allowing for potential contamination. The Dietary Manager turned the items upside down, and indicated upright items could gather dust or debris.

At the bottom of the same clean dish rack, two opened cans of lighter fluid were sitting amongst various dish/utensil items. The Dietary Manager indicated the lighter fluid should be stored with other chemicals.

The stove top and griddle grease traps were both covered with aluminum foil, and each contained grease, crumbs, and burnt debris. The Dietary Manager indicated the aluminum foil should be replaced once soiled and the amount of buildup in the grease traps was not acceptable.

A deep fryer was covered on all visible sides by grease and food splatters. On the floor, on either side of the fryer, were two large cardboard boxes, flattened, and soaked with grease. The Dietary Manager indicated these were

used to catch grease from the fryer.

A small serving tray containing condiments was covered with crumbs and debris. The bottom of a bottle of an unidentified liquid, when lifted, had crumbs stuck to the bottom. The Dietary Manager indicated the crumbs could fall into food items when the condiment(s) were in use.

The Dietary Manager indicated there was a cleaning log and he would provide the log after the observation. No cleaning log(s) were located during the observation.

During an interview with the Administrator on 2/4/26 at 10:45 a.m., she indicated the kitchen did not maintain cleaning logs.

A current facility policy, titled "Cleaning Frequency", provided by the DON on 2/4/26 at 3:00 p.m., indicated the following: " ...To provide a clean work environment and insure food safety to our community and staff ...b) To prevent cross-contamination, kitchenware and food-contact surfaces of equipment shall be washed, rinsed, and sanitized after each use and following any interruption of operations during which time contamination may have occurred ...d) The food-contact surfaces of grills, griddles, and similar cooking

	devices ....shall be cleaned at least- once a day except that this shall not apply to hot oil cooking equipment and of oil filtering systems. The food-contact surfaces of all cooking equipment shall be kept free of encrusted grease deposits and other accumulated soil ...e) Non-food-contact surfaces of equipment shall be cleaned as often as is necessary to keep the equipment free of accumulation of dust, dirt, food particles, and other debris ...."			

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