

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/22/2025	
NAME OF PROVIDER OR SUPPLIER VITA OF MARION		STREET ADDRESS, CITY, STATE, ZIP CODE 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. Survey dates: April 21 and 22, 2025 Facility number: 015081 Residential Census: 89 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed April 28, 2025.	R 0000					
R 0042	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(p) (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation and	R 0042	1 The Executive Director/ Designee will place missing surveys in the survey binder			05/30/2025	

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interview, the facility failed to have the most recent State Survey results readily available to the public. This deficiency had the potential to affect 89 of 89 residents residing in the facility.

Finding includes:

During an observation on 4/22/25 at 11:24 a.m., accompanied by the Director of Nursing (DON), the State Survey binder was located at the front desk, near the front door of the facility. A review of the binder's contents indicated it lacked survey results from the last annual survey completed 7/22/24. The DON confirmed the most recent annual survey was not located in the binder.

During an interview on 4/22/25 at 12:26 p.m., the DON indicated the facility did not have a policy for the State Survey binder. The facility followed state regulations.

During an interview on 4/22/25 at 3:32 p.m., the Administrator indicated the facility did not have a policy for the State Survey binder. The facility followed state regulations.

Based on observation and interview, the facility failed to have the most recent State Survey results readily available to the public. This deficiency had the potential to affect 89 of

2

All residents have potential to be affected by alleged deficient practice.

3

The Executive Director/ designee will audit the State Survey Binder monthly to ensure compliance.

4

Audit will be reviewed by the facility QAPI committee for x6 months to ensure compliance.

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	89 residents residing in the facility. Finding includes: During an observation on 4/22/25 at 11:24 a.m., accompanied by the Director of Nursing (DON), the State Survey binder was located at the front desk, near the front door of the facility. A review of the binder's contents indicated it lacked survey results from the last annual survey completed 7/22/24. The DON confirmed the most recent annual survey was not located in the binder. During an interview on 4/22/25 at 12:26 p.m., the DON indicated the facility did not have a policy for the State Survey binder. The facility followed state regulations. During an interview on 4/22/25 at 3:32 p.m., the Administrator indicated the facility did not have a policy for the State Survey binder. The facility followed state regulations.			
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows:	R 0092	No residents are affected by the alleged deficient procedure. The Executive Director will in-service Maintenance Director on state requirements regarding fire drill regulation. Maintenance Director/ designee will conduct a	05/30/2025

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(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.

(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.

Based on interview and record review, the facility failed to ensure fire drills were conducted. This deficient practice had the potential to affect 89 of 89 residents residing in the facility.

Findings include:

fire drill quarterly on each shift.

Fire

Drill compliance will be monitored by the facility QAPI committee for x6 months to ensure compliance.

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Facility fire drill records, provided on 4/22/25 at 9:30 a.m. by the Administrator, indicated no fire drills were completed between October 2024 through January 2025.

During an interview, on 4/22/25 at 9:41 a.m., the Maintenance Director indicated he had only performed one fire drill since his employment in February 2025.

During an interview, on 4/22/25 at 10:23 a.m., the Administrator indicated there had been no fire drills performed since he started his employment in October 2024. Fire drills should be done at least quarterly on all three shifts.

During an interview, on 4/22/25 at 2:57 p.m., the Administrator indicated the facility did not have a policy regarding fire drills. The facility follows the National Fire Protection Association (NFPA) 101/ Life Safety Code and the TELS system shows fire drills should be conducted at least quarterly.

Based on interview and record review, the facility failed to ensure fire drills were conducted. This deficient practice had the potential to affect 89 of 89 residents residing in the facility.

Findings include:

Facility fire drill records,

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	provided on 4/22/25 at 9:30 a.m. by the Administrator, indicated no fire drills were completed between October 2024 through January 2025. During an interview, on 4/22/25 at 9:41 a.m., the Maintenance Director indicated he had only performed one fire drill since his employment in February 2025. During an interview, on 4/22/25 at 10:23 a.m., the Administrator indicated there had been no fire drills performed since he started his employment in October 2024. Fire drills should be done at least quarterly on all three shifts. During an interview, on 4/22/25 at 2:57 p.m., the Administrator indicated the facility did not have a policy regarding fire drills. The facility follows the National Fire Protection Association (NFPA) 101/ Life Safety Code and the TELS system shows fire drills should be conducted at least quarterly.			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (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:	R 0217	Resident 91 is no longer a resident of the community. Director of Nursing/designee will audit all service plans to ensure each residents has a signed service plan. Director of Nursing/ designee will in-service staff on service plan required signatures.	05/30/2025

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(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 a service plan was signed by the resident for 1 of 7		Any deficiencies will be corrected at time of observation. Director of Nursing/designee will audit all service plans weekly x1 week and then monthly x6 months. QAPI committee will review service plans audits monthly x6 months to ensure compliance	
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residents reviewed for service plans. (Resident 91)

Finding includes:

Resident 91's clinical record was reviewed on 4/21/25 at 3:43 p.m. Current diagnoses included hypothyroidism, dementia, anxiety disorder, hypertension, and chronic kidney disease.

The resident's clinical record contained a current Service Plan dated 2/21/25. The document was not signed by the resident or the resident's representative.

During an interview with the DON on 4/21/25 at 1:02 p.m., she indicated Resident 91's current 2/21/25 Service Plan was not signed by the resident or the resident's representative.

A current facility policy, dated 6/2022 and provided by the DON on 4/22/25 at 3:18 p.m., titled "Service Plans," indicated the following: "Purpose: The purpose of this policy is to outline necessary components of the resident evaluation and assessment process to ensure that the individual needs, desires, and preferences of the resident are obtained and noted in the Service Plan as needed and appropriate within the frequency and assessment schedule specified. Policy: Each resident will have a written plan

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of care that is developed based on initial evaluation/assessment, semiannual assessments, and with any changes in resident needs. This plan will be available for staff review to assist in the daily care/services provided to the resident...Procedure: The Director of Nursing, or designee, is responsible for overseeing, managing, and ensuring 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...4. 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 a service plan was signed by the resident for 1 of 7 residents reviewed for service plans. (Resident 91)

Finding includes:

Resident 91's clinical record was reviewed on 4/21/25 at 3:43 p.m. Current diagnoses included hypothyroidism, dementia, anxiety disorder, hypertension, and chronic kidney disease.

The resident's clinical record

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contained a current Service Plan dated 2/21/25. The document was not signed by the resident or the resident's representative.

During an interview with the DON on 4/21/25 at 1:02 p.m., she indicated Resident 91's current 2/21/25 Service Plan was not signed by the resident or the resident's representative.

A current facility policy, dated 6/2022 and provided by the DON on 4/22/25 at 3:18 p.m., titled "Service Plans," indicated the following: "Purpose: The purpose of this policy is to outline necessary components of the resident evaluation and assessment process to ensure that the individual needs, desires, and preferences of the resident are obtained and noted in the Service Plan as needed and appropriate within the frequency and assessment schedule specified. Policy: Each resident will have a written plan of care that is developed based on initial evaluation/assessment, semiannual assessments, and with any changes in resident needs. This plan will be available for staff review to assist in the daily care/services provided to the resident...Procedure: The Director of Nursing, or designee, is responsible for overseeing, managing, and ensuring the following...D. Following

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	completion of an evaluation, a licensed nurse in the Community shall identify and document the services to be provided by the Community, as follows...4. 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. A. Based on observation, interview, and record review, the facility failed to label, date, and store foods and dining utensils under safe sanitary conditions. This deficiency had the potential to impact 89 of 89 residents receiving meals from the facility. B. Based on observation and interview, the facility failed to ensure food was served under safe sanitary conditions regarding food handling during meal service. This deficient practice had the potential to affect 89 of 89 residents who received their meals from the	R 0273	The Executive Director will in-service Dietary Manager on proper safe food regulations by date of compliance. The Dietary Manager/designee will Inservice staff on proper safe food handling and storage of food items. Dietary Manager/designee will audit inventory for appropriate labels, date, and storage of food daily x30 days weekly x4 weeks and monthly x6 months. The QAPI committee will review the audits monthly x6 months The Dietary Manager/designee will audit the cleanliness of the dining room daily x30 days, weekly x4 weeks, and monthly x6 months. Variances will be corrected at the time of observation and findings will be reviewed by the community's QAPI committee x6 months.	05/30/2025

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kitchen.

C. Based on observation and interview, the facility failed to ensure the dining room was kept in a sanitary manner. This deficient practice had the potential to affect 89 of 89 residents.

Findings include:

A. During a continuous kitchen observation beginning on 4/21/25 at 9:40 a.m. and ending at 10:30 a.m., accompanied by the Dietary Manager (DM), the following was observed:

A rolling cart, with an uncovered bin of ice on the top shelf, was sitting near the dishwasher and an open trash can. A scoop was laying inside the bin of ice. The DM indicated the rolling cart had recently been returned from the breakfast dining service.

A can of Mexican style chili beans, dated 1/2/25, had a large dent on one end of the can. A can of mandarin oranges, dated 4/15/25, had a large dent on the side. A can of Cream of Chicken soup, dated 3/14/15, had two medium sized dents on the side. A can of applesauce, dated 4/8/25, had large dents on both sides of one end of the can.

During an interview with the DM, he indicated damaged cans would still be used unless the

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damage was very bad, in which case he would send them back. He pointed to the can of mandarin oranges as an example of something they would use even though it was dented. If food was leaking from the can, he would send it back.

In the dry storage area, a large bin of beef flavored base, with an open date of 1/28/25, had the lid sitting askew on the top. The lid was not sealed. The DM indicated the lid should have been sealed.

The freezer contained an uncovered dish of a white pureed substance. The manager could not identify what was in the dish, but indicated a staff member may have placed it in the freezer for themselves. Staff had been instructed to cover and date items in the freezer.

The refrigerator contained a large rack with pumpkin pie slices on individual plates. The rack was covered with a bag which resembled a light-colored trash bag. There were no dates on the cover or on the individual slices of pie. The manager indicated the pie was from the previous day. The plan was to put the slices of pie in individual, dated foam containers for service later.

The deep fryer had many

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crumbs on the front edge and the stainless-steel splash guard on the right side of the fryer was covered with grease splatters.

The stove top backsplash had a buildup of burnt grease behind the rear, right burner. It was black in color and about the size of a serving platter.

During a kitchen observation on 4/22/25 at 2:24 p.m., a large bin of sugar had a scoop laying inside on top of the sugar. A large bin of flour had a scoop laying inside on top of the flour. A large bin of oatmeal had a scoop laying inside on top of the oatmeal.

A small trash can, sitting next to the ice machine, contained food and was uncovered.

A large, gray trash can was sitting to the right of the deep fryer, beneath the spice rack, and was uncovered.

A large, industrial sized rack contained dining service ware. The bowls and pitchers were in an upright position.

During an interview with the DM on 4/22/25 at 2:30 p.m., he indicated the bins of flour, sugar, and oatmeal should all be dated. Scoops should not be stored inside the containers. The trash cans should be covered, especially in areas where food was prepared. The

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bowls and pitchers should be stored upside-down.

A current facility policy, dated 7/2024, provided by the Administrator on 4/22/5 at 3:00 p.m., titled "Dry Food Storage", indicated the following:
"Purpose: Proper storage of dry foods is crucial for preserving freshness, flavor, and nutritional value. Policy: 1. Food, whether raw or prepared, if removed from the container or package in which it was obtained shall be in a clean, covered container except during periods of preparation or service ...7. Unless its identity is unmistakable, bulk food such as cooking oil, syrup, salt, sugar, or flour not stored in the product container or package in which it was obtained, shall be stored in a container identifying the food by its name. 8. The delivery date shall be written or identified on each product....."

No other kitchen policies were provided by the facility.

B. During a lunch observation, on 4/21/25 at 12:04 p.m., the following food handling and food service concerns were observed:

Dietary Employee 4 (DE 4) touched a residents walker handle with her gloved hands. She then walked over to the drink containers where she

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grabbed a foam cup by placing her right index finger inside the cup. She then proceeded to fill the cup with ice. She placed the ice scoop into the ice container, where it fell over, and the handle touched the remaining ice. She placed a can of soda inside the foam cup, on top of the ice, before serving the drink to a resident.

DE 4 held three foam cups against her body while she filled the cups with ice.

DE 4, wearing gloves, walked over to the drink station and retrieved a lid for a foam cup that a resident had requested. She touched the bottom side of the lid when she handed it to the resident.

DE 4, wearing the same gloves, walked over to the countertop and picked up a plate to deliver to a resident. Her right thumb touched the food portion of the plate.

DE 4, wearing gloves, took her left gloved hand, reached inside her right gloved hand, and pulled her right glove down.

DE 4, wearing the same gloves, walked over and scraped dirty dish plates into the trash can. After scraping off the dirty plates, she walked over and helped place covers on plates for Memory Care. She grabbed the handle of the three-wheeled

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cart and pushed it toward the dessert cart.

DE 4, wearing gloves, removed a flower vase from the center of a table and placed it in the windowsill before she pulled out a chair for a resident. Wearing the same gloves, she walked over and grabbed a plate. Her right thumb touched the food portion of the plate.

During an interview, on 4/21/25 at 1:26 p.m., DE 4 indicated she should not have held the foam cups against her body when she filled them with ice. She should not have placed the can of soda inside the foam cup. It slipped her mind to change her gloves after she removed the vase off the table and placed it on the windowsill. She should be performing hand hygiene after taking off her used gloves.

During a breakfast observation, on 4/22/25 at 7:50 a.m., the following handling and food service concerns were observed:

Dietary Employee 5 (DE 5) was observed with his gloved hands. He placed lids on plates before placing them on a wheeled cart. While wearing gloves, he grabbed the handle to adjust the cart. While he grabbed food plates, his right thumb touched the food portion of the plate before covering the plate with a

lid.

DE 5, while wearing a glove on his right hand, pulled his cellphone halfway out of his pocket with his right hand, pushed his phone back in his pocket, then placed a glove on his left hand. He walked over to the drink station, grabbed a Styrofoam cup, touched the waterspout, and delivered the drink to a resident. While wearing the same gloves, he picked up a plate and his right thumb touched the food portion of the plate while delivering it to a resident.

DE 5 was observed not wearing a beard net during the entire meal service. He had a full beard that was longer than the length of a pencil eraser.

During an interview, on 4/22/25 at 8:59 a.m., DE 5 indicated he should have performed hand hygiene after touching his phone. He should have worn a beard net during the meal service.

CNA 6 was observed wearing gloves. She touched the waterspout to fill a foam cup and delivered the drink to a resident. While wearing the same gloves, she then walked over and placed bread into the toaster.

CNA 6 was observed taking off a used pair of gloves. She wiped her nose with the pads of

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her fingers before donning a new pair of gloves. No hand hygiene was performed. She then walked over to the cook and started placing foil over plates before placing them on top of a wheeled cart.

CNA 6 was observed removing old gloves and putting on new gloves without performing hand hygiene during the entire breakfast observation.

During an interview, on 4/22/24 at 9:05 a.m., CNA 6 indicated she should have washed her hands before putting on new gloves. She did take her glove off, wiped her nose, and put on new gloves without performing any hand hygiene.

CNA 7 was observed taking a drink from her Styrofoam cup before putting on gloves. No hand hygiene was performed.

During an interview, on 4/22/25 at 9:14 a.m., CNA 7 indicated she should have washed her hands after she drank from her drink before putting on gloves. The drink spouts were clean when they first came down. The residents could use the drink spouts to pour their own drinks.

During an interview, on 4/22/25 at 10:23 a.m., the Administrator indicated DE 5 should have worn a beard net during meal service. Staff should wash their hands before placing on a new

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set of gloves.

During an interview, on 4/22/25 at 2:30 p.m., the Dietary Manager indicated DE 5 should have worn a beard net during the meal service. The facility had beard nets available.

A current policy, titled "Front of the House Service Policy and Procedure", provided by the Administrator, on 4/22/25 at 2:55 p.m., indicated the following: " ...Be sure to hold the base of the glass, do not touch the rim of the glass"

A current policy, titled "Culinary Dress Code and Requirements", provided by the DON, on 4/22/25 at 10:01 a.m., indicated the following: " ...beard nets must be worn if facial hair is longer than 1/8th of an inch long"

C. During a random observation, on 4/22/25 at 7:38 a.m., the facility's temporary dining room/activity room had crumbs all over the floor under the second table on the left upon entering the room. Popcorn was spilled on the floor under three tables near the popcorn machine. There was a brown substance on the seat of a chair. There were white and brown stains on the seat backs of numerous chairs. There was a quarter sized dark brown/ honey colored food item, that

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appeared to be a piece of meat, on the floor underneath the table where the toast machine was located. Three white stains were noted in the carpet under the toaster. At the opposite end of the table, there was a trash can that had numerous brown crumb-like substances on the floor around the trash can. There was a used, white plastic creamer container sitting on the floor in-between the brown crumbs.

During an observation, on 4/22/25 at 7:48 a.m., housekeeping entered the room and swept up the popcorn that was spilled underneath the three tables with a broom and dustpan.

During an interview, on 4/22/25 at 10:23 a.m., the Administrator indicated housekeeping cleaned the room at the end of the day. Residents had been dining in the activities room since January 2025. The facility did not have a cleaning policy or schedule for that specific area.

A. Based on observation, interview, and record review, the facility failed to label, date, and store foods and dining utensils under safe sanitary conditions. This deficiency had the potential to impact 89 of 89 residents receiving meals from the facility.

B. Based on observation and

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interview, the facility failed to ensure food was served under safe sanitary conditions regarding food handling during meal service. This deficient practice had the potential to affect 89 of 89 residents who received their meals from the kitchen.

C. Based on observation and interview, the facility failed to ensure the dining room was kept in a sanitary manner. This deficient practice had the potential to affect 89 of 89 residents.

Findings include:

A. During a continuous kitchen observation beginning on 4/21/25 at 9:40 a.m. and ending at 10:30 a.m., accompanied by the Dietary Manager (DM), the following was observed:

A rolling cart, with an uncovered bin of ice on the top shelf, was sitting near the dishwasher and an open trash can. A scoop was laying inside the bin of ice. The DM indicated the rolling cart had recently been returned from the breakfast dining service.

A can of Mexican style chili beans, dated 1/2/25, had a large dent on one end of the can. A can of mandarin oranges, dated 4/15/25, had a large dent on the side. A can of Cream of Chicken soup, dated 3/14/15, had two medium sized

dents on the side. A can of applesauce, dated 4/8/25, had large dents on both sides of one end of the can.

During an interview with the DM, he indicated damaged cans would still be used unless the damage was very bad, in which case he would send them back. He pointed to the can of mandarin oranges as an example of something they would use even though it was dented. If food was leaking from the can, he would send it back.

In the dry storage area, a large bin of beef flavored base, with an open date of 1/28/25, had the lid sitting askew on the top. The lid was not sealed. The DM indicated the lid should have been sealed.

The freezer contained an uncovered dish of a white pureed substance. The manager could not identify what was in the dish, but indicated a staff member may have placed it in the freezer for themselves. Staff had been instructed to cover and date items in the freezer.

The refrigerator contained a large rack with pumpkin pie slices on individual plates. The rack was covered with a bag which resembled a light-colored trash bag. There were no dates on the cover or on the individual

slices of pie. The manager indicated the pie was from the previous day. The plan was to put the slices of pie in individual, dated foam containers for service later.

The deep fryer had many crumbs on the front edge and the stainless-steel splash guard on the right side of the fryer was covered with grease splatters.

The stove top backsplash had a buildup of burnt grease behind the rear, right burner. It was black in color and about the size of a serving platter.

During a kitchen observation on 4/22/25 at 2:24 p.m., a large bin of sugar had a scoop laying inside on top of the sugar. A large bin of flour had a scoop laying inside on top of the flour. A large bin of oatmeal had a scoop laying inside on top of the oatmeal.

A small trash can, sitting next to the ice machine, contained food and was uncovered.

A large, gray trash can was sitting to the right of the deep fryer, beneath the spice rack, and was uncovered.

A large, industrial sized rack contained dining service ware. The bowls and pitchers were in an upright position.

During an interview with the DM

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on 4/22/25 at 2:30 p.m., he indicated the bins of flour, sugar, and oatmeal should all be dated. Scoops should not be stored inside the containers. The trash cans should be covered, especially in areas where food was prepared. The bowls and pitchers should be stored upside-down.

A current facility policy, dated 7/2024, provided by the Administrator on 4/22/5 at 3:00 p.m., titled "Dry Food Storage", indicated the following:
"Purpose: Proper storage of dry foods is crucial for preserving freshness, flavor, and nutritional value. Policy: 1. Food, whether raw or prepared, if removed from the container or package in which it was obtained shall be in a clean, covered container except during periods of preparation or service ...7. Unless its identity is unmistakable, bulk food such as cooking oil, syrup, salt, sugar, or flour not stored in the product container or package in which it was obtained, shall be stored in a container identifying the food by its name. 8. The delivery date shall be written or identified on each product....."

No other kitchen policies were provided by the facility.

B. During a lunch observation, on 4/21/25 at 12:04 p.m., the following food handling and food

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service concerns were observed:

Dietary Employee 4 (DE 4) touched a residents walker handle with her gloved hands. She then walked over to the drink containers where she grabbed a foam cup by placing her right index finger inside the cup. She then proceeded to fill the cup with ice. She placed the ice scoop into the ice container, where it fell over, and the handle touched the remaining ice. She placed a can of soda inside the foam cup, on top of the ice, before serving the drink to a resident.

DE 4 held three foam cups against her body while she filled the cups with ice.

DE 4, wearing gloves, walked over to the drink station and retrieved a lid for a foam cup that a resident had requested. She touched the bottom side of the lid when she handed it to the resident.

DE 4, wearing the same gloves, walked over to the countertop and picked up a plate to deliver to a resident. Her right thumb touched the food portion of the plate.

DE 4, wearing gloves, took her left gloved hand, reached inside her right gloved hand, and pulled her right glove down.

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DE 4, wearing the same gloves, walked over and scraped dirty dish plates into the trash can. After scraping off the dirty plates, she walked over and helped place covers on plates for Memory Care. She grabbed the handle of the three-wheeled cart and pushed it toward the dessert cart.

DE 4, wearing gloves, removed a flower vase from the center of a table and placed it in the windowsill before she pulled out a chair for a resident. Wearing the same gloves, she walked over and grabbed a plate. Her right thumb touched the food portion of the plate.

During an interview, on 4/21/25 at 1:26 p.m., DE 4 indicated she should not have held the foam cups against her body when she filled them with ice. She should not have placed the can of soda inside the foam cup. It slipped her mind to change her gloves after she removed the vase off the table and placed it on the windowsill. She should be performing hand hygiene after taking off her used gloves.

During a breakfast observation, on 4/22/25 at 7:50 a.m., the following handling and food service concerns were observed:

Dietary Employee 5 (DE 5) was observed with his gloved hands.

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He placed lids on plates before placing them on a wheeled cart. While wearing gloves, he grabbed the handle to adjust the cart. While he grabbed food plates, his right thumb touched the food portion of the plate before covering the plate with a lid.

DE 5, while wearing a glove on his right hand, pulled his cellphone halfway out of his pocket with his right hand, pushed his phone back in his pocket, then placed a glove on his left hand. He walked over to the drink station, grabbed a Styrofoam cup, touched the waterspout, and delivered the drink to a resident. While wearing the same gloves, he picked up a plate and his right thumb touched the food portion of the plate while delivering it to a resident.

DE 5 was observed not wearing a beard net during the entire meal service. He had a full beard that was longer than the length of a pencil eraser.

During an interview, on 4/22/25 at 8:59 a.m., DE 5 indicated he should have performed hand hygiene after touching his phone. He should have worn a beard net during the meal service.

CNA 6 was observed wearing gloves. She touched the

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waterspout to fill a foam cup and delivered the drink to a resident. While wearing the same gloves, she then walked over and placed bread into the toaster.

CNA 6 was observed taking off a used pair of gloves. She wiped her nose with the pads of her fingers before donning a new pair of gloves. No hand hygiene was performed. She then walked over to the cook and started placing foil over plates before placing them on top of a wheeled cart.

CNA 6 was observed removing old gloves and putting on new gloves without performing hand hygiene during the entire breakfast observation.

During an interview, on 4/22/24 at 9:05 a.m., CNA 6 indicated she should have washed her hands before putting on new gloves. She did take her glove off, wiped her nose, and put on new gloves without performing any hand hygiene.

CNA 7 was observed taking a drink from her Styrofoam cup before putting on gloves. No hand hygiene was performed.

During an interview, on 4/22/25 at 9:14 a.m., CNA 7 indicated she should have washed her hands after she drank from her drink before putting on gloves. The drink spouts were clean when they first came down. The

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residents could use the drink spouts to pour their own drinks.

During an interview, on 4/22/25 at 10:23 a.m., the Administrator indicated DE 5 should have worn a beard net during meal service. Staff should wash their hands before placing on a new set of gloves.

During an interview, on 4/22/25 at 2:30 p.m., the Dietary Manager indicated DE 5 should have worn a beard net during the meal service. The facility had beard nets available.

A current policy, titled "Front of the House Service Policy and Procedure", provided by the Administrator, on 4/22/25 at 2:55 p.m., indicated the following: " ...Be sure to hold the base of the glass, do not touch the rim of the glass"

A current policy, titled "Culinary Dress Code and Requirements", provided by the DON, on 4/22/25 at 10:01 a.m., indicated the following: " ...beard nets must be worn if facial hair is longer than 1/8th of an inch long"

C. During a random observation, on 4/22/25 at 7:38 a.m., the facility's temporary dining room/activity room had crumbs all over the floor under the second table on the left upon entering the room. Popcorn was spilled on the floor

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under three tables near the popcorn machine. There was a brown substance on the seat of a chair. There were white and brown stains on the seat backs of numerous chairs. There was a quarter sized dark brown/ honey colored food item, that appeared to be a piece of meat, on the floor underneath the table where the toast machine was located. Three white stains were noted in the carpet under the toaster. At the opposite end of the table, there was a trash can that had numerous brown crumb-like substances on the floor around the trash can. There was a used, white plastic creamer container sitting on the floor in-between the brown crumbs.

During an observation, on 4/22/25 at 7:48 a.m., housekeeping entered the room and swept up the popcorn that was spilled underneath the three tables with a broom and dustpan.

During an interview, on 4/22/25 at 10:23 a.m., the Administrator indicated housekeeping cleaned the room at the end of the day. Residents had been dining in the activities room since January 2025. The facility did not have a cleaning policy or schedule for that specific area.

R 0409	Infection Control - Noncompliance	R 0409	Director	05/30/2025
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410 IAC 16.2-5-12(d)

(d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter.

Based on record review and interview, the facility failed to verify by statement, on admission and annually, that residents were free from infectious tuberculosis for 7 of 7 residents reviewed for annual health statements. (Residents 54, 78, 2, 59, 82, 91, and 92,)

Findings include:

Resident 54's clinical record was reviewed on 4/21/25 at 10:35 a.m., and lacked an annual health statement.

Resident 78's clinical record was reviewed on 4/21/25 at 11:36 a.m., and lacked an annual health statement.

Resident 2's clinical record was reviewed on 4/21/25 at 11:44 a.m., and lacked an annual health statement.

of Nursing/designee will educate nursing staff on requirements of annual health statements by date of compliance. The Director of Nursing/designee will request annual health statements for any resident that do not currently have one. Director of Nursing/designee will audit all resident charts for annual health statement.

Residents found not to have annual health statement will have one completed and signed by residents physician.

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Resident 59's clinical record was reviewed on 4/21/25 at 4:19 p.m., and lacked an annual health statement.

Resident 82's clinical record was reviewed on 4/21/25 at 2:58 p.m., and lacked an annual health statement.

Resident 91's clinical record was reviewed on 4/21/25 at 3:43 p.m., and lacked an annual health statement.

Resident 92's clinical record was reviewed on 4/22/25 at 10:32 a.m., and lacked an annual health statement.

During an interview with the DON on 4/22/25 at 3:19, she indicated the facility did not have annual health statements or an annual health statement policy. The facility followed state regulations.

During an interview on 4/22/25 at 3:32 p.m., the Administrator indicated the facility did not have an annual health statement policy. The facility followed state regulations.

Based on record review and interview, the facility failed to verify by statement, on admission and annually, that residents were free from infectious tuberculosis for 7 of 7 residents reviewed for annual health statements. (Residents 54, 78, 2, 59, 82, 91, and 92,)

Findings include:

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Resident 92's clinical record was reviewed on 4/22/25 at

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FORM APPROVED

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OMB NO. 0938-0391

10:32 a.m., and lacked an annual health statement.

During an interview with the DON on 4/22/25 at 3:19, she indicated the facility did not have annual health statements or an annual health statement policy. The facility followed state regulations.

During an interview on 4/22/25 at 3:32 p.m., the Administrator indicated the facility did not have an annual health statement policy. The facility followed state regulations.

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