STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PRIMROSE OF MISHAWAKA	820 FULMER ROAD MISHAWAKA, IN 46544

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: May 12 & 13, 2025 Facility number: 013439 Residential Census: 39 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 5/15/2025	R 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. The facility is respectfully requesting paper compliance in lieu of a post-survey revisit.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview and record review, the facility failed to ensure food was stored, prepared and served under sanitary conditions in 1 of 1 kitchen observed. This had the potential to affect 39 of 39 residents who consumed food from the kitchen. Findings include: 1. During a tour of the kitchen, on 5/12/2025 at 9:45 A.M., with Cook 2, the following was observed: -- Old Bay seasoning, liquid butter alternative, soybean oil, vanilla, Worcestershire sauce, honey, sesame oil and Quaker Oats were all opened and undated. In the upright freezer: -- a box of tilapia and 2 boxes of biscuits were opened and not sealed properly.	R 0273	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Although no specific residents were directly harmed, the potential for foodborne illness existed due to improperly labeled, stored, and unsanitary food items and equipment. Immediate corrective actions included: 1. Discarding all undated and improperly stored food items (e.g., opened oils, seasoning, oats, tilapia, biscuits). 2.Removing and disposing of the cracked container of mushrooms. 3.Rewashing and sanitizing all visibly soiled kitchen equipment	05/30/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laurine Ringer	Executive DIrector	06/06/2025

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	In the upright refrigerator: -- a large plastic storage container with fresh, sliced mushrooms was unlabeled and the bottom of the storage container was cracked. During an interview, on 5/12/2025 at 9:45 A.M., Cook 2 indicated the products should have had an open and use by date on the container. The opened boxes of tilapia and biscuits in the freezer should have been sealed properly. Cook 2 indicated the cracked container of mushrooms should not have been used. 2. During a follow-up observation of the kitchen, on 5/13/2025 at 11:30 A.M., the following was observed: --Six loaf pans and one spatula, put away as clean, had dried food debris on them. --A three-shelf metal cart, used for food transportation, was noted to have food particles on the top shelf and the bottom shelf had a dried liquid stain. During an interview, on 5/13/2025 at 11:45 A.M., the Dietary manager indicated the dirty items should have been cleaned. On 5/13/2025 at 12:59 P.M., the Administrator provided a Standard Operating Procedure, titled "Community Food-Labeling and Dating", dated 11/06/2024. The procedure indicated " ...Establish a date marking system and train employees accordingly ...label with the product name, the date it was prepared or opened...."		(loaf pans, spatula, transport cart). 4.Reinforcing safe food handling protocols with dietary staff, including Cook 2. How will other residents having the potential to be affected by the same deficient practice(s) be identified and what corrective action(s) will be taken; All residents receiving meals from the dietary department were potentially at risk due to these issues. 1. A comprehensive inspection of all food storage areas and equipment was conducted to identify and correct deficiencies. 2.All food preparation and storage containers were reviewed, and any unlabeled or improperly stored items were discarded. 3.Kitchen staff underwent immediate re-education on proper labeling, food storage, and sanitation practices. 4.Damaged containers and unsealed packaging were replaced or removed. What measures will be put into place or what systemic changes will be made to ensure the deficient practice(s) does not recur; and 1.All dietary staff were re-trained on the community's food labeling and dating policy. 2.Mandatory	

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			in-service training was conducted on cleaning, labeling, sealing, and safe food storage procedures. 3.A labeling station with waterproof labels and permanent markers was set up. 4.Updated kitchen cleaning checklists include verification of cleanliness before items are stored. 5.Transport carts and kitchen equipment are now part of a rotating deep-clean schedule. How will the corrective action(s) be monitored to ensure solutions are sustained and the deficient practice will not recur. A plan must be developed to make sure correction is achieved and sustained (i.e., what quality assurance program will be put into place); Ongoing compliance with this corrective action will be monitored through the Quality Assurance program. The Dining director or designee will be responsible for completion of the quality assurance program audit tool for food labeling, dating, storage, and cleaning. The audit will be performed three times per week x 1 month, then two times per week x 1 month, then one time per week x 4 months. If the threshold of 90% is met after three months, then monitoring can be stopped. Finding will be submitted to the	

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			quality assurance program for further review and follow up. By what date the corrective action(s) and/or systemic change(s) will be completed. The completion date must be within acceptable time frame. All corrective actions and changes will be fully implemented and completed by: May 30, 2025	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance Based on record review and interview, the facility failed to ensure an infection control program, including monitoring and trending any infections, was maintained . This had the potential to affect 39 of 39 residents. Finding includes: A review of the facility's infection control binder was completed on 5/13/2025 at 10:02 A.M. The binder had monthly line listings forms for tracking the Covid virus, dated September and October 2023. The Infection Control binder lacked any current documentation to indicate which residents had had infections, when the infections had started, what type of infection they had, how had the infections been treated, what was the outcome after treatment and any tracking and trending of the infections. On 5/13/2025 at 10:39 A.M., the Director of Nursing provided copies of forms, titled "Incident Report", for the date range from 1/1/2025 to 4/30/2025 from the electronic charting system	R 0407	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No specific residents were directly harmed. 1. All 22 residents identified as having infections from 1/1/2025 to 4/30/2025 were reviewed for complete documentation and any missing data was updated. 2.Staff were educated on accurately completing incident reports in real time to avoid future omissions How will other residents having the potential to be affected by the same deficient practice(s) be identified and what corrective action(s) will be taken; All current and future residents are	05/30/2025

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	utilized by the facility.. Under the section titled "Report Filters" incident type for Infections was generated. The form was divided into sections- resident name, occurred at, incident details, and status. The form indicated there had been 22 residents with infections and 6 residents with repeated infection for the date ranges documented generated from above. The Incident Report forms lacked the incident details regarding the outcome. The documentation under the status section indicated "not completed 8 of 10 tasks completed, or 10 of 10 tasks completed." During an interview, on 5/13/2025 at 11:29 A.M., the Director of Nursing indicated the facility used to have a book with the infections logged, but the facility had switched computer companies and now was using (name of electronic charting system) program and everything was on the computer. However, the Director of Nursing indicated she had not completed the tracking and trending of the infections utilizing the information generated from the Report Filters- Infections. On 5/13/2025 at 12:13 P.M., the Administrator provided the policy titled, "Infection Control Monitoring Policy", dated 12/1/2024, and indicated the policy was the one currently use by the facility. The policy indicated "... All infections-related events must be documented in (name of electronic charting system) and reviewed regularly by the Director of Nursing or designee... Infection Log. Maintain observation notes within (name of electronic charting system) for: Date of symptoms onset. Type of infection. Interventions provided. Outcome (recovered, ongoing, hospitalized, sect.) The DON or designee will review this weekly and during Quality Assurance meetings...."		potentially at risk due to the oversight of monitoring and documentation gap. 1.Updated infection records were reviewed to ensure compliance with the facility's Infection Control Monitoring Policy. 2.The DON or designee will review new infection cases weekly to ensure full data capture for all residents. What measures will be put into place or what systemic changes will be made to ensure the deficient practice(s) does not recur; and 1.All licensed nursing staff have been trained on the "Infection control policy'" as well as re-educated on the proper entry of entering complete infection data. 2.The DON or designee will review all new infection entries to ensure full compliance with documentation requirements and trend infections. How will the corrective action(s) be monitored to ensure solutions are sustained and the deficient practice will not recur. A plan must be developed to make sure correction is achieved and sustained (i.e., what quality assurance program will be put into place); Ongoing compliance with this	

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			corrective action will be monitored through the Quality Assurance program. The DON or designee will be responsible for completion of the quality assurance program audit tool for infection control. The audit will be performed three times per week x 1 month, then two times per week x 1 month, then one time per week x 4 months. If the threshold of 90% is met after three months, then monitoring can be stopped. Finding will be submitted to the quality assurance program for further review and follow up. By what date the corrective action(s) and/or systemic change(s) will be completed. The completion date must be within acceptable time frame. All corrective actions and systemic improvements were fully implemented and completed by May 30, 2025.	