

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

PRINTED: 08/06/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 06/11/2024	
NAME OF PROVIDER OR SUPPLIER BROOKDALE RICHMOND				STREET ADDRESS, CITY, STATE, ZIP COD 3700 SOUTH A STREET RICHMOND, IN 47374			
(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: June 10 & 11, 2024 Facility number: 010888 Residential Census: 20 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 13, 2024.			R 0000	The following is the Plan of Correction for Brookdale Richmond regarding the Statement of Deficiencies dated 6/11/2024. The Plan of Correction is not to be construed as an admission of or agreement with the findings and sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.		
R 0274 Bldg. 00	410 IAC 16.2-5-5.1(g)(1-3) Food and Nutritional Services - Noncompliance (g) There shall be an organized food service department directed by a supervisor competent in food service management and knowledgeable in sanitation standards, food handling, food preparation, and meal service. (1) The supervisor must be one (1) of the following: (A) A dietitian. (B) A graduate or student enrolled in and						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 08/06/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/11/2024	
NAME OF PROVIDER OR SUPPLIER BROOKDALE RICHMOND				STREET ADDRESS, CITY, STATE, ZIP COD 3700 SOUTH A STREET RICHMOND, IN 47374			
(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
	<p>within one (1) year from completing a division approved, minimum ninety (90) hour classroom instruction course that provides classroom instruction in food service supervision who has a minimum of one (1) year of experience in some aspect of institutional food service management.</p> <p>(C) A graduate of a dietetic technician program approved by the American Dietetic Association.</p> <p>(D) A graduate of an accredited college or university or within one (1) year of graduating from an accredited college or university with a degree in foods and nutrition or food administration with a minimum of one (1) year of experience in some aspect of food service management.</p> <p>(E) An individual with training and experience in food service supervision and management.</p> <p>(2) If the supervisor is not a dietitian, a dietitian shall provide consultant services on the premises at peak periods of operation on a regularly scheduled basis.</p> <p>(3) Food service staff shall be on duty to ensure proper food preparation, serving, and sanitation.</p> <p>1. Based on observation, interview, and record review, the facility failed to ensure dietary staff were knowledgeable about the chemical concentration of the sanitization bucket, implemented dating of opened and prepared food items, and had completed and documented dishwasher temperature checks during 1 of 2 observation of the kitchen.</p> <p>2. Based on observation, interview, and record review, the facility failed to ensure that a three-door freezer was kept in a clean condition and that a thermometer was accessible for the</p>			R 0274	<p>* Corrective Actions taken immediately upon notification of alleged deficient practice; Open food without dates was discarded immediately per the cook. An evaluation of community refrigerators/freezers were audited for compliance for community opened container policy and cleanliness and cleaned.</p> <p>*What corrective action(s) will be accomplished for those residents affected by the deficient practice; No residents affected by</p>		07/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/11/2024	
NAME OF PROVIDER OR SUPPLIER BROOKDALE RICHMOND				STREET ADDRESS, CITY, STATE, ZIP COD 3700 SOUTH A STREET RICHMOND, IN 47374			
(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
	<p>chest deep freezer for 2 of 4 cold storage containers.</p> <p>Findings include:</p> <p>1. The initial observation of the kitchen was completed on 6/10/2024 at 10:40 a.m. with Dietary Aide 2.</p> <p>During an interview and observation of the kitchen on 6/10/2024 at 10:40 a.m., two pitchers of orange juice, one pitcher of lemonade, two bowls of pineapples covered with plastic wrap, and two containers of sliced cheese covered in plastic wrap were observed in the cold storage areas without dates. Dietary Aide 2 indicated he did not prepare those items, but he was working on cycling out the undated items when we had walked in. He immediately disposed of those items.</p> <p>During an interview and observation of the kitchen on 6/10/2024 at 10:51 a.m., the dishwasher check log was observed on the wall across from the dishwasher. The log had not been completed since June 7, 2024. Dietary Aide 2 said he had not been here over the weekend, so he was not sure why they were not completed. When asked if the dishwasher was high temperature or chemical, Dietary Aide 2 was not sure and indicated to the detergent that it uses "that".</p> <p>During an interview and observation of the kitchen on 6/10/2024 at 10:55 a.m., the sanitation bucket was observed on the front counter. Dietary Aide 2 was asked to do a chemical strip test to ascertain concentration levels, and he indicated he did not know where the chemical strip tests were, but that he routinely utilized his past knowledge to discern that it was up to</p>				<p>the alleged deficient practice.</p> <p>*How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Alleged deficient practice has the potential to affect all residents.</p> <p>· What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Associates working in dining were re-educated on dating open food items. Per Community policy dining staff members re-educated on proper temperature checks of refrigerators and freezers. They will also be reeducated on proper sanitization bucket PPMs, and cleaning schedules.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The dining associates will complete daily checklist and the dining services coordinator will verify compliance. The dining service coordinator will complete daily sanitation audit for one month, then will complete them three times weekly for one month then complete weekly.</p> <p>The Executive Director will also complete weekly sanitation audits to verify the completion.</p>		

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

PRINTED: 08/06/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 06/11/2024	
NAME OF PROVIDER OR SUPPLIER BROOKDALE RICHMOND				STREET ADDRESS, CITY, STATE, ZIP COD 3700 SOUTH A STREET RICHMOND, IN 47374			
(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
	<p>concentration. The solution within the bucket appeared an opaque blue at this time.</p> <p>A follow up observation of the kitchen was completed on 6/11/2024 at 11:00 a.m. with Dietary Aide 3.</p> <p>A policy entitled, "Washing and Sanitizing Dishes (Machine Wash)", was provided by the Administrator on 6/10/2024 at 1:45 p.m. The policy indicated, " ...Low and High temperature dish machines must be taken and recorded on the temperature log ..."</p> <p>A sanitization bucket log entitled, "Sani-Pail Test Log", was provided by the Administrator on 6/11/2024 at 12:10 p.m. The log indicated " ...Appropriate test strips must be available and utilized ..."</p> <p>A policy entitled, "Labeling - DS04.028", was provided by the Administrator on 6/11/2024 at 12:10 p.m. The policy indicated, " ...All prepared items (i.e. leftovers or prepared for next meal) must have a label with the name of item, date prepared, by whom, and date of discard ..."</p> <p>2. The initial walk through of the kitchen was completed on 6/10/2024 at 10:40 a.m. with Dietary Aide 2.</p> <p>During an interview and observation of the kitchen on 6/10/2024 at 10:45 a.m., a large amount of food crumbs and residue were observed on bottom of the three-door freezer. Dietary Aide 2 indicated that it has been like that for a while, and he had just completed reorganizing the freezer after their Dietary Supervisor quit last week.</p> <p>During an interview and observation of the</p>				<p>By what date will the systemic changes will be completed 7/22/2024</p>		

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

PRINTED: 08/06/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 06/11/2024	
NAME OF PROVIDER OR SUPPLIER BROOKDALE RICHMOND				STREET ADDRESS, CITY, STATE, ZIP COD 3700 SOUTH A STREET RICHMOND, IN 47374			
(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
	<p>kitchen on 6/10/2024 at 10:50 a.m., a chest deep freezer was observed in the dry storage area. The temperature log for the deep freezer was not filled out for 6/10/2024 a.m. and when Dietary Aide 2 opened the freezer, no thermometer was observed. Dietary Aide 2 said the thermometer was probably buried in the bottom, but he knew the items were good because they were "frozen solid" and he when he filled out the form, he would just copy down what was written the day before.</p> <p>During an interview with the Administrator on 6/11/2024 at 12:10 p.m. indicated that food storage areas, including the cold storage freezers, should be kept in a cleanly condition and should have accessible thermometers to have temperatures obtained per policy.</p> <p>An equipment temperature log, entitled "Temperature Log - Equipment", was provided by the Administrator on 6/11/2024 at 12:10 p.m. The log indicated, "Food holding equipment temperatures must be monitored and recorded every four hours ..."</p>						