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	04/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LEGACY LIVING OF JASPER LLC	1850 WEST STATE ROAD 56 JASPER, IN 47546

(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: April 12, 13, 2021 Facility number: 014383 Residential Census: 69 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 15, 2021.	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 any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk Review in lieu of a Post Survey Review.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review the facility failed to ensure hand sanitization was performed before delivering residents' food trays, and that the food stored in the kitchen was dated and covered for 1 of 2 observations of the kitchen and 1 of 2 observations of food service delivery. Staff touched silverware and the inside of a bowl with bare hands, and placed items on top of cooked food for 1 of 2 observations of meal service. Findings include: 1. During one of two observations of the kitchen on 4/12/21 at 10:05 A.M., the following was observed:	R 0273	No residents were found to have been affected by this deficiency. All residents have the potential to be affected by this deficiency. In-service for all kitchen staff by 4/23/21 will include review of policies for handling of opened food, hand sanitizing best practices, and infection control as related to serving. Director or designee will monitor compliance 3 times per week for the first 4 weeks, 2 times per week for the next 4 weeks, and 1 time per week for the following 4 weeks. All changes will be completed by	04/23/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Located in the front refrigeration unit was an undated apple pie, one half jar of undated mayonnaise. Located on a proofing rack were two trays of uncovered rolls. Located in the reach-in refrigeration was one half block of uncovered and undated cream cheese and one opened and undated package of Havarti cheese. Located in the dry storage area was one opened and undated bag of Cinnamon Toast Crunch cereal, one opened and undated bag of Honey Nut Crunch cereal, one opened and undated bag of Rice Crispies Cereal, and one opened and undated box of Carrot Cake mix. Located in the Serving area was one bag of opened and undated Granola cereal. Located in the ice cream freezer was a partially used and uncovered two gallon container of Blue Berry Waffle ice cream. During an interview on 4/12/21 at 10:45 A.M., the Dietary Manager indicated all food packages were supposed to have the open date posted on the package. All food was supposed to be covered, including all food items in both the refrigerators and the freezers. 2. During one of two observations of lunch tray deliveries on 4/12/13 at 11: 16 A.M., the following was observed: Server 1 delivered lunch trays to the following residents:		4/23/21.	

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	At 11:16 A.M., without sanitizing her hands, Server 1 knocked on the door to Resident 14's room, opened the door with the bare hand, delivered a drink, and exited Resident 14's room. Server 1 did not hand sanitize after exiting the resident's room At 11:17 A.M., without sanitizing her hands, Server 1 removed the lunch tray from the food service cart, knocked on the door to Resident 15's room, opened the door touching the door handle, delivered the lunch tray, and touched the door handle to exit the room. Server 1 did not hand sanitize after exiting Resident 15's room. At 11:18 A.M., without sanitizing her hands, Server 1 removed the lunch tray from the food service cart, knocked on the door to Resident 16's room, opened the door touching the door handle, delivered the tray, and touched the door handle to exit the room. Server 1 did not hand sanitize after exiting the Resident 16's room. Server 1 proceeded to the elevator with the food service cart and used her finger to push the elevator call button. Server 1 exited the elevator on the 2nd floor and proceeded to deliver lunch trays. At 11:20 A.M., without sanitizing her hands, Server 1 removed the lunch tray from the food service cart and knocked on the door to Resident 17's room, opened the door touching the door handle, delivered the tray, and touched the door handle to exit the room. Server 1 did not hand sanitize after exiting Resident 17's room. At 11:23 A.M., without sanitizing her hands, Server 1 removed the lunch tray from the food			

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	service cart and knocked on the door to Resident 18's room, opened the door touching the door handle, delivered the tray, and touched the door handle to exit the room. Server 1 did not hand sanitize after leaving Resident 18's room. At 11:24 A.M., without sanitizing her hands, Server 1 removed the lunch tray from the food service cart and knocked on the door to Resident 8's room, opened the door touching the door handle, delivered the tray, and touched the door handle to exit the room. Server 1 did not hand sanitize after exiting Resident 8's room. At 11:25 A.M., without sanitizing her hands, Server 1 removed the lunch tray from the food service cart and knocked on the door to Resident 20's room, opened the door touching the door handle, delivered the tray, and touched the door handle to exit the room. Server 1 did not hand sanitize after exiting Resident 20's room. During an interview on 2/12/21 at 11:27 A.M., Server 1 indicated she generally had a hand sanitizer bottle attached to the service cart, but this foodservice cart did not have one. Server 1 said there was a hand sanitizer station mounted on the wall by the elevator and that she would hand sanitize before going downstairs. During an interview on 2/13/21 at 11:07 A.M., Server 8 indicated hand sanitization should be performed before and after exiting a resident's room whenever food trays were delivered. 3. During a continuous observation on 4/12/21 between 11:00 A.M. and 11:30 A.M., the following was observed: Server 8 placed 2 jelly packs on a plate, leaning against a piece of chicken. The tray was taken to			

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	the hall to serve to a resident. Server 8 scooped soup inside of a bowl with her thumb inside the bowl, then served it to Resident 8. Server 8 did not perform hand hygiene before handling the bowl. Server 8 picked up a set of silverware, handled the tip where the silverware was exposed, then placed on a tray to be served to a resident. Server 8 did not perform hand hygiene before handling the silverware. During an interview on 4/13/21 at 11:09 A.M., Server 5 indicated staff should only handle silverware by the napkin that is holding it, staff should place items such as cracker packs and jelly packets on the tray, and are not supposed to let them touch the food. Server 5 indicated staff should only handle the outside of bowls, and not touch the rim or the inside of the bowl when serving soup. An undated policy titled, "Handling of Food", which was provided by the Administrator and reviewed on 4/13/21 at 11:40 A.M., read as follows: "...To provide quality food that is handled in a safe and sanitary manner...5. Food must be dated when opened and appropriately discarded in accordance with safe food handling standards...7. a. Staff must sanitize hands between each meal tray when delivering room trays..." During an interview on 4/13/21 at 1:27 P.M., the Administrator indicated it is the facility policy to not touch silverware with bare hands, to not touch the inside of bowls with bare hands, and to not place items such as jelly packets on food to be served.			

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R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, interview, and record review, the facility failed to ensure a glucometer was cleaned after use and follow the manufacturers instructions for frequency of cleaning, for 1 of 1 observations of glucometer use (Resident 12). Finding includes: On 4/12/21 at 11:10 A.M., during observation of a medication pass, LPN 4 indicated she needed to obtain an accucheck blood sugar on Resident 12. LPN 4 indicated each resident had their own glucometer, and removed Resident 12's glucometer from the medication cart. After obtaining the resident's blood, and inserting the test strip into the glucometer, LPN 4 put the glucometer back into its case. The glucometer machine was not cleaned at that time. LPN 4 indicated the facility policy was to clean the glucometers once a week. The clinical record of Resident 12 was reviewed on 4/12/21 at 1:15 P.M. A Physician's order, initially dated 12/31/19 and on the current April	R 0407	No residents were found to have been affected by this deficiency. 10 residents have the potential to be affected by this deficiency. In-service for all licensed nurses by 4/23/21 will include review of updated policy for cleaning of glucometer after each use. Director or designee will monitor compliance 3 times per week for the first 4 weeks, 2 times per week for the next 4 weeks, and 1 time per week for the following 4 weeks. All changes will be completed by 4/23/21.	04/23/2021

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	2021 orders, indicated, "Blood Sugar check three times daily." On 4/12/21 at 1:30 P.M., LPN 4 indicated she was not the only nurse who used Resident 12's glucometer. On 4/12/21 at 1:45 P.M., the Director of Nursing (DON) provided the manufacturer's guidelines for Resident 12's glucometer. The guidelines included, "Meter care, Cleaning and Disinfection. Cleaning removes blood and soil from the meter. Disinfecting removes most, but not all possible infectious agents (bacteria or virus) from the meter, including blood borne pathogens...If the meter is being operated by a second person who provides testing assistance, the meter and the lancing device should be cleaned and disinfected prior to use by the second person...." On 4/12/21 at 2:00 P.M., the Administrator provided the current facility policy on "Infection Control - Glucometer Use," undated. The policy included, "Personal glucometer machines will be cleaned weekly with approved disinfectant according to manufacturer guidelines."			