PRINTED: 04/28/2021 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  IDENTIFICATION MIMBER  A BUILING B WING  STREET ADDRESS, CITY, STATE, 7IP COD 1850 WEST STATE ROAD 56 JASPER ILC  IN JID SUMMARY STATEMENT OF DEFICIENCIE REGACY LIVING OF JASPER ILC  IN JID SUMMARY STATEMENT OF DEFICIENCIE REGULATORY OR LSC IDENTIFYING INFORMATION  R 0000  Bidg. 00  This visit was for a State Residential Licensure Survey. Survey dates: April 12, 13, 2021  Facility number: 014883 Residential Ceasus: 69 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 15, 2021.  R 0273  Bidg. 00  R 0273  Bidg. 00  A 10 IAC 16.2-5. It() Food and Nutritional Services - Deficiency (I) 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 finding to ensure hand sanitization was performed before delivering residents' food rays, and that the food stored in the kitchen was dated and covered for 1 of 2 observations of find 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 the kitchen on 41221 at 10.05 A.M., the following was observed:  STREET ADDRESS, CITY, STATE, 7IP COD 1850 WEST STATE ROAD 56 JASPER. IN 47546  JAS	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X		X3) DATE SURVEY			
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R 0273  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  R 0273  No residents were found to have been affected by this deficiency. All residents have the potential to be affected by this deficiency. All residents have the potential to be affected by this deficiency. All residents have the potential to be affected by this deficiency. All residents have the potential to be affected by this deficiency. All residents have the potential to be affected by this deficiency. All residents have the potential to be affected by this deficiency. All residents have the potential to be affected by this deficiency. All residents have the potential to be affected by this deficiency. All residents have the potential to be affected by this deficiency. All residents have the potential to be affected by this deficiency. All residents have the potential to be affected by this deficiency. All residents have the potential to be affected by this deficiency. All residents have the potential to be affected by this deficiency. All residents have the potential to be affected by this deficiency. All residents have the potential to be affected by this deficiency. All residents have the potential to be affected by this deficiency. All residents have the potential to be affec		accordance with 41	0 IAC 16.2-5.					
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on 4/12/21 at 10:05 A.M., the following was week for the following 4 weeks. All		1.0	1 64 1			•	ie	
		•				·	A 11	
Cnanges will be completed by			A.M., the following was			_	s. All	
		ouserved:				changes will be completed by		

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclodays 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.

State Form Event ID: 1JJZ11 Facility ID: 014383 If continuation sheet Page 1 of 7

PRINTED: 04/28/2021 FORM APPROVED OMB NO. 0938-039

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00		LETED B/2021			
	PROVIDER OR SUPPLIER		1850 W	STREET ADDRESS, CITY, STATE, ZIP COD 1850 WEST STATE ROAD 56 JASPER, IN 47546					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE	(X5) COMPLETION DATE			
		refrigeration unit was an one half jar of undated		4/23/21.					
	Located on a proofi uncovered rolls.	ng rack were two trays of							
	block of uncovered	n-in refrigeration was one half and undated cream cheese undated package of Havarti							
	and undated bag of cereal, one opened a Nut Crunch cereal,	torage area was one opened Cinnamon Toast Crunch and undated bag of Honey one opened and undated bag real, and one opened and ot Cake mix.							
	Located in the Servi opened and undated	ing area was one bag of Granola cereal.							
		ream freezer was a partially two gallon container of Blue eam.							
	Dietary Manager in supposed to have the package. All food was a supposed to have the package.	on 4/12/21 at 10:45 A.M., the dicated all food packages were e open date posted on the was supposed to be covered, ems in both the refrigerators							
	_	o observations of lunch tray 3 at 11: 16 A.M., the following							
	Server 1 delivered l residents:	unch trays to the following							

State Form Event ID: 1JJZ11 Facility ID: 014383 If continuation sheet Page 2 of 7

PRINTED: 04/28/2021 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER					l	COMPLETED 04/13/2021	
			B. WING			04/13/	2021
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD EST STATE ROAD 56		
LEGACY	LIVING OF JASPE	ER LLC			R, IN 47546		
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY O.	R LSC IDENTIFYING INFORMATION	TAG				DATE
	At 11:16 A.M., wit	thout sanitizing her hands,					
		on the door to Resident 14's					
	room, opened the d	loor with the bare hand,					
		and exited Resident 14's room.					
		nd sanitize after exiting the					
	resident's room						
	   At 11:17 A M wit	thout sanitizing her hands,					
	· ·	the lunch tray from the food					
		ed on the door to Resident 15's					
	room, opened the d	loor touching the door handle,					
		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,						
		the lunch tray from the food					
	service cart, knock	ed on the door to Resident 16's					
	_	loor touching the door handle,					
	· ·	and touched the door handle to					
		rer 1 did not hand sanitize after					
	exiting the Resider	it 16's room.					
	Server 1 proceeded	to the elevator with the food					
	_	ed her finger to push the					
	elevator call buttor	a. Server 1 exited the elevator					
		d proceeded to deliver lunch					
	trays.						
	At 11:20 A.M wit	thout sanitizing her hands,					
		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						
	sanıtıze atter exitin	g Resident 17's room.					
	At 11:23 A.M., wit	thout sanitizing her hands,					
		the lunch tray from the food					
		-					

State Form Event ID: 1JJZ11 Facility ID: 014383 If continuation sheet Page 3 of 7

PRINTED: 04/28/2021 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	00	COMPLETED	
			B. WING		04/13/2021	
	PROVIDER OR SUPPLIE		1850 W	ADDRESS, CITY, STATE, ZIP COD VEST STATE ROAD 56 R, IN 47546		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		ocked on the door to Resident				
	_	the door touching the door				
		he tray, and touched the door				
		room. Server 1 did not hand				
	sanıtıze after leavı	ng Resident 18's room.				
	A+ 11,24 A M wi	thout conitizing har hands				
		thout sanitizing her hands, the lunch tray from the food				
		locked on the door to Resident				
		he door touching the door				
	_	he tray, and touched the door				
		room. Server 1 did not hand				
	sanitize after exitir	ng Resident 8's room.				
	Δt 11:25 Δ M wi	thout sanitizing her hands,				
		the lunch tray from the food				
		locked on the door to Resident				
		the door touching the door				
		he tray, and touched the door				
		room. Server 1 did not hand				
	sanitize after exiting	ng Resident 20's room.				
		w on 2/12/21 at 11:27 A.M.,				
		she generally had a hand				
		ached to the service cart, but				
		art did not have one. Server 1				
		and sanitizer station mounted				
	1	elevator and that she would				
	nand sanitize befor	re going downstairs.				
	During an intervie	w on 2/13/21 at 11:07 A.M.,				
		hand sanitization should be				
	-	and after exiting a resident's				
	1 ~	od trays were delivered. 3.				
		us observation on 4/12/21				
	_	M. and 11:30 A.M., the following				
	was observed:					
		elly packs on a plate, leaning				
	against a piece of o	chicken. The tray was taken to				

State Form Event ID: 1JJZ11 Facility ID: 014383 If continuation sheet Page 4 of 7

PRINTED: 04/28/2021 FORM APPROVED OMB NO. 0938-039

B. WING	COMPLETED 04/13/2021
NAME OF PROVIDER OR SUPPLIER  LEGACY LIVING OF JASPER LLC  STREET ADDRESS, CITY, STATE, ZIP COD  1850 WEST STATE ROAD 56  JASPER, IN 47546	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)  the hall to serve to a resident.	(X5) COMPLETION DATE
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 manner5. Food must be dated when opened and appropriately discarded in accordance with safe food handling standards7. 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 the inside of bowls 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.	

State Form Event ID: 1JJZ11 Facility ID: 014383 If continuation sheet Page 5 of 7

PRINTED: 04/28/2021 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00 COMP.		COMPL	TE SURVEY MPLETED 113/2021		
NAME OF PROVIDER OR SUPPLIER  LEGACY LIVING OF JASPER LLC			STREET ADDRESS, CITY, STATE, ZIP COD  1850 WEST STATE ROAD 56  JASPER, IN 47546				
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE		
R 0407 Bldg. 00	control program the (1) A system that a analyze patterns of symptoms.  (2) Provides orient education on infectincluding universa (3) Offering health including, but not I transmission and it (4) Reporting compublic health author Based on observation review, the facility was cleaned after us manufacturers instructed (Resident 12).  Finding includes:  On 4/12/21 at 11:10 medication pass, LP obtain an accucheck LPN 4 indicated each glucometer, and renglucometer from the obtaining the reside test strip into the glugucometer back into machine was not clean indicated the facility glucometers once a The clinical record on 4/12/21 at 1:15 Fermions of the clinical record on 4/12/21 at 1:15 Fermions or the clinical record on 4/12/21 at 1:15 Fermions or the clinical record on 4/12/21 at 1:15 Fermions or the clinical record on 4/12/21 at 1:15 Fermions or the clinical record on 4/12/21 at 1:15 Fermions or the clinical record on 4/12/21 at 1:15 Fermions or the clinical record on 4/12/21 at 1:15 Fermions or the clinical record on 4/12/21 at 1:15 Fermions or the clinical record on 4/12/21 at 1:15 Fermions or the clinical record on 4/12/21 at 1:15 Fermions or the clinical record on 4/12/21 at 1:15 Fermions or the clinical record on 4/12/21 at 1:15 Fermions or the clinical record on 4/12/21 at 1:15 Fermions or the clinical record on 4/12/21 at 1:15 Fermions or the clinical record on 4/12/21 at 1:15 Fermions or the clinical record on 4/12/21 at 1:15 Fermions or the clinical record on 4/12/21 at 1:15 Fermions or the clinical record on 4/12/21 at 1:15 Fermions or the clinical record on 4/12/21 at 1:15 Fermions or the clinical record of 4/12/21 at 1:15 Fermions or the clinical record of 4/12/21 at 1:15 Fermions or the clinical record of 4/12/21 at 1:15 Fermions or the clinical record of 4/12/21 at 1:15 Fermions or the clinical record of 4/12/21 at 1:15 Fermions or the clinical record of 4/12/21 at 1:15 Fermions or the clinical record of 4/12/21 at 1:15 Fermions or the clinical record of 4/12/21 at 1:15 Fermions or the clinical record	Noncompliance st establish an infection at includes the following: enables the facility to of known infectious tation and in-service stion prevention and control, I precautions. information to residents, imited to, infection mmunizations. municable disease to orities. on, interview, and record failed to ensure a glucometer se and follow the actions for frequency of observations of glucometer.  A.M., during observation of a control of a control of the location of the locations of glucometer. In the location of the locatio	R 04	107	No residents were found to habeen affected by this deficience 10 residents have the potential be affected by this deficiency. In-service for all licensed nurse by 4/23/21 will include review updated policy for cleaning of glucometer after each use. Director or designee will monit compliance 3 times per week the first 4 weeks, 2 times per week for the next 4 weeks, and time per week for the following weeks. All changes will be completed by 4/23/21.	ey. I to es of or for	04/23/2021

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING		(X3) DATE SURVEY COMPLETED 04/13/2021			
NAME OF PROVIDER OR SUPPLIER  LEGACY LIVING OF JASPER LLC				STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPRIA DEFICIENCY)	тЕ	(X5) COMPLETION DATE	
	2021 orders, indicatimes daily."	ted, "Blood Sugar check three						
		P.M., LPN 4 indicated she was who used Resident 12's						
	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.							
	Disinfecting remov infectious agents (b	blood and soil from the meter. es most, but not all possible acteria or virus) from the bod borne pathogensIf the						
	provides testing ass	ated by a second person who istance, the meter and the ald be cleaned and disinfected second person"						
	provided the curren Control - Glucomet included, "Personal	P.M., the Administrator t facility policy on "Infection er Use," undated. The policy glucometer machines will be h approved disinfectant facturer guidelines."						

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