STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155785	A. BUILDING 00 B. WING	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WEST RIVER HEALTH CAMPUS	714 S EICKHOFF RD EVANSVILLE, IN 47712

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: May 9, 10, 11, 12, 15, 2023 Facility number: 012448 Provider number: 155785 AIM number: 201039500 Census Bed Type: SNF/NF: 19 SNF: 14 Residential: 52 Total: 85 Census Payor Type: Medicare: 8 Medicaid: 19 Other: 6 Total: 33 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 24, 2023.	F 0000	The submission of this plan of correction does not indicate an admission by West River Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of West River Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. Corrections to be completed by **6/9/23**.	
F 0582 SS=A Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lisa Stallman, RN-BC	Clinical Support	06/08/2023

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	charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds			

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	due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. Based on interview and record review, the facility failed to provide necessary documentation to ensure a resident or responsible party was issued a Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) before the proposed end of services for 2 of 3 beneficiary notices reviewed. (Resident 7, Resident 13) Findings include: On 5/12/23 at 9:18 A.M., during review of three randomly chosen resident Medicare Part A discharge notices, Resident 7 and Resident 13's notice stated, "The facility/provider initiated the discharge from Medicare Part A services when benefit days were not exhausted," and a SNF ABN notification form was not provided, and a written note was provided from the facility that stated "Rcd [sic] services under MCD [sic]." On 5/12/23 9:29 A.M., the social services director indicated Resident 7 and Resident 13 were transferred from Medicaid to Medicare due to contracting Covid 19. The residents were transferred back to Medicaid after the Covid 19 coverage ended. On 5/15/23 8:58 A.M., a policy was requested. At that time, the Regional Consultant indicated they do not have a policy, and that the facility honors CMS (Centers for Medicare and Medicaid Services) guidelines for completing ABN's. 3.1-4(i)	F 0582	No plan of correction needed	06/09/2023

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F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be			

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	extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on observation, interview and record review, the facility failed to ensure residents were free from unnecessary medications for 1 of 5 residents reviewed for unnecessary medications. A resident's as needed anti-anxiety medication was ordered for greater than 14 days (Resident 10). Finding includes: On 5/10/23 at 11:53 A.M., Resident 10 was observed sitting up in reclining wheelchair, legs covered, call light in reach, eyes closed, snoring, bedside table next to resident. On 5/11/23 at 10:05 A.M., Resident 10 was observed sitting in reclining wheelchair, eyes closed, blanket over her legs with call light in reach. On 5/12/23 at 10:36 A.M., Resident 10 was observed sitting in reclining wheelchair, call light in reach, and bedside table next to resident. On 5/15/23 at 10:48 A.M., Resident 10 was observed sitting in reclining wheelchair, call light in reach, bedside table next to resident. Resident 10 was yelling out "Hey." On 5/11/23 at 10:07 A.M., Resident 10's clinical	F 0758	1. Resident #10 was assessed, no adverse effects noted from psychotropic medication use. Resident is on hospice services and orders updated to reflect hospice end of life care. 2. All like residents have the potential to be affected by the alleged deficiency. Resident #10 medications updated to reflect hospice end of life care. Education completed with licensed nursing staff on Psychotropic Medication Usage and Gradual Dose Reduction policy and procedure. 3. DHS/designee will audit psychotropic medications to ensure documentation present for risk vs benefits, orders designate if being used for hospice end of life care. Audits will consist of like resident's random audit of 3 residents orders weekly x 4 weeks, every other week x 4 weeks, and monthly x 4 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until	06/09/2023

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	record was reviewed. Diagnosis included, but was not limited to, dementia, with other behavioral disturbance, anxiety disorder, and depression. The current quarterly MDS (Minimum Data Set) assessment, dated 2/3/23, indicated Resident 10 was moderately impaired, was currently on hospice, and received an anti-anxiety medication 7 of 7 days of the assessment look back period. Current physician's orders included, but were not limited to, "lorazepam - Schedule IV tablet; 0.5 mg [milligram]; amt: 0.5 MG; oral Special Instructions: dx [diagnosis]: Anxiety or agitation. To give sublingual, crush and mix with 0.5 ml [milliliter] h20 [water] Every 30 Minutes - PRN [as needed]" dated 9/30/22. There was no extension of the medication ordered by the physician. Review of the MAR (medication administration record) indicated Resident 10 received lorazepam 0.5 mg prn on the following dates: 10/2/22 8:14 A.M. behavior 10/4/22 8:33 P.M. yelling out 10/8/22 9:43 A.M. yelling out 10/16/22 8:11 A.M. yelling into hallway 10/18/22 8:20 A.M. behavior 11/7/22 10:35 A.M. very anxious and crying 11/8/22 10:09 A.M. behavior issues 11/9/22 10:14 A.M. behavior issues 11/10/22 9:58 A.M. behavior issues 11/12/22 10:37 A.M. anxiety 11/13/22 8:56 A.M. anxiety 12/7/22 6:25 P.M. anxious 12/12/22 8:49 P.M. anxiety 12/16/22 6:31 P.M. restlessness 12/31/22 3:41 P.M. pain 1/4/23 2:24 A.M. anxiety 2/11/23 12:10 A.M. behavior issues 2/19/23 11:03 A.M. behavior issues		campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months, if needed, until 100% compliance met.	

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	3/1/23 8:07 P.M. anxious 3/26/23 6:38 P.M. behavior issues, crying unconditionally 4/25/23 3:24 P.M. pain 5/9/23 2:34 P.M. anxiety 5/11/23 8:54 P.M. restlessness Review of the nurses notes indicated the following: 11/14/2022 11:03 A.M. "Spoke with (Name of Hospice) nurse (Name of Nurse) regarding resident increase in anxiety and restless behavior also that resident is yelling out more to have nursing staff come in room, and attempting to climb out of bed. Orders given to make Lorazepam 0.5 mg TID [three times a day] routinely due to resident behaviors. Started routine Lorazepam this am, will monitor resident for effectiveness and any other side effects." Nursing (Name of Nurse) During an interview on 5/15/23 at 11:40 A.M., the Regional Consultant indicated the ordering physician had not done an assessment every 14 days since the lorazepam prn was ordered on 9/30/22. On 5/15/23 at 11:52 A.M., a current Psychotropic Medication Usage and Gradual Dose Reductions policy, dated 10/9/17, was provided and indicated "PRN order for psychotropic drugs are limited to 14 days. Except as provided if the attending physician or prescriber believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluated the resident for the appropriateness of that			

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	medication". 3.1-48(a)(6)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, interview, and record review, the facility failed to ensure it was free of a medication error rate of greater than 5 percent (%) for 2 of 6 residents (Resident 14, Resident 238)observed during medication pass. 2 medication errors were observed during 25 opportunities for error in medication administration. This resulted in a medication error rate of 8%. A resident choked and was unable to swallow large portion of unidentified partially crushed medication and the incorrect dose of an ordered medication was given to a resident. Findings include: 1. On 5/10/23 at 8:18 A.M., LPN (Licensed Practical Nurse) 3 was observed to crush and administer the following 10 medications to Resident 14: amlodipine 5 mg (milligram) (for blood pressure) Buspar 7.5 mg (for mood) calcium 600 mg (for osteoporosis) Carbidopa/Levodopa 25/100 mg (for Parkinson's disease) vitamin D3 1000 IU (international unit) (vitamin to help with calcium absorption) docusate sodium 100 mg (stool softener) lisinopril 5 mg (for blood pressure) omeprazole 20 mg (for stomach)	F 0759	1. Resident #14 was assessed, no adverse effects noted from alleged deficient practice. Resident #238 was assessed and no adverse effected noted from alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficiency. Nursing staff educated on medication administration policy with focus on medication refusals and crushing medications. 3. DHS or designee will conduct random audits of medication administration observations during medication pass. Audit will be at random and will be on random hallways and times, will be completed 3 times a week x 4 weeks, weekly x 4 weeks, every other week x 4 weeks, and then monthly x 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until	06/09/2023

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	UTI stat liquid 30 mL (milliliter) in a cup (UTI prevention) venlafaxine 37.5 mg (for mood) While the resident was drinking a liquid after the spoonful of crushed medications mixed with applesauce, Resident 14 started coughing. Resident 14 took a piece of a white pill the size of a pencil eraser from her mouth and put it in a Kleenex held by LPN 3. LPN 3 disposed of the pill. At that time, LPN 3 indicated he did not know what pill it was. During an interview on 5/15/23 at 11:00 A.M., the Regional Consultant indicated a medication spit out by a resident was treated as a refusal and staff should have documented in the EHR the circumstances as to why the resident refused it. 2. On 5/10/23 at 8:44 A.M., LPN 3 was observed to administer 1 pill of Senexon-S 8.6-50mg for constipation to Resident 238. The current physician's orders included, but were not limited to, the following medication: Senexon-S (sennosides-docusate sodium) tablet; 8.6-50 mg 2 tablets by mouth twice a day During an interview on 5/15/23 at 11:50 A.M., the Regional Consultant indicated physician's orders should be followed when administering medications. A current Medication Administration policy, revised 11/2018, was provided by the Regional Consultant and indicated " ... Medications are administered in accordance with written orders of the prescriber ... If a dose of regularly scheduled medication is withheld, refused ... it is documented on MAR (medication administration record) or in		campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months, if needed, until 100% compliance met.	

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	the EHR. An explanatory note is also entered ... ". 3.1-48(c)(1)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure proper storage of medications for 2 of 2 medication carts and 2 of 2 medication storage rooms observed. Loose pills were observed in the medication cart drawers, and temperature logs were not completely filled out for the refrigerator in the medication rooms (200 Hall,	F 0761	1. No residents noted to have any adverse effects from alleged deficiency of loose pills noted in medication carts, loose pill noted in medication room, refrigerator temperature logs not filled out completely. Audit completed on	06/09/2023

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	300 Hall). Findings include: 1. On 5/12/23 at 9:42 A.M., the 200 Hall medication cart was reviewed. The following loose pills were observed in the bottom of the drawers: 1 pink oblong pill with marking "894/5" ½ white rectangle pill with marking "B" 2 yellow oblong pills with marking "80/A" 1 pink circle pill with marking "C/74" 2 white circle pills with marking "AN/44" 1 yellow oblong pill with marking "A/18" 1 dark red circle pill with marking "421/U" 1 blue circle pill with marking "L/24" 1 white rectangle pill with marking "B15" 1 pink oval pill with marking "29/1" 1 peach circle pill with marking "318/93" 1 white circle pill with marking "099" 1 yellow oval pill with marking "152" ½ blue circle pill with no marking visible (2) ½ green oblong pills with no marking visible ½ dark red circle pill with no marking visible 1 white capsule with marking "FL/72" At that time, LPN 3 indicated when staff observed loose pills in the medication carts, they should dispose of them. LPN 3 indicated he was unsure who was responsible for cleaning the medication carts. On 5/12/23 at 9:55 A.M., the 300 Hall medication cart was observed. The following loose pills were observed in the bottom of the drawers: 1 white circle pill with marking "HP/24" 1 yellow oval pill with marking "152" ½ dark red circle pill with no marking visible 1 white oval pill with marking "APO/A10" At that time, RN 7 indicated night shift was responsible for cleaning out the medication carts.		medication carts, medication rooms, and medication refrigerators to ensure all medication stored appropriately. 2. All residents have the potential to be affected by the alleged deficiency. Nursing staff educated on medication storage and refrigerator temperature logs being filled out completely. 3. DHS or designee will conduct random audits of medication carts to ensure no loose pills noted. Audit will be at random and will be on random hallways and times, will be completed 3 times a week x 4 weeks, weekly x 4 weeks, every other week x 4 weeks, and then monthly x 3 months. DHS or designee will conduct random audits of medication rooms ensure no loose pills noted, medication stored according to policy. Audit will be at random and will be on random hallways and times, will be completed 3 times a week x 4 weeks, weekly x 4 weeks, every other week x 4 weeks, and then monthly x 3 months. DHS or designee will conduct random audits of temperature logs to ensure logs are filled out completely. Audit will be at random and will be on random hallways and times, will be completed 3 times a week x 4 weeks, weekly x 4 weeks, every other week x 4 weeks, and then	

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	2. On 5/12/23 at 9:42 A.M., the 200 Hall medication storage room was observed. The May 2023 temperature log posted on the refrigerator lacked temperatures for the following days: 5/1/23 5/2/23 5/5/23 5/6/23 5/7/23 5/8/23 5/10/23 5/11/23 At that time, LPN 3 indicated night shift was responsible for filling out the refrigerator temperature logs in the medication storage rooms. 3. On 5/12/23 at 9:55 A.M., the 300 Hall medication storage room was observed. The April 2023 temperature log was blank with no temperatures filled in. The May 2023 temperature log posted on the refrigerator lacked temperatures for the following days: 5/3/23 5/10/23 In the 300 Hall medication storage room, two green circle pills with marking "RP101" were observed sitting loose on a cabinet shelf. At that time, RN 7 indicated night shift was responsible for filling out the refrigerator temperature logs in the medication storage rooms, and pills should not be loose in the medication storage room cabinets. On 5/12/23 at 11:30 A.M., a current medication storage policy, revised 11/18, was provided and indicated "Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures and humidity ... The Facility should check the refrigerator or freezer in which vaccines		monthly x 3 months. 1. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months, if needed, until 100% compliance met.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WEST RIVER HEALTH CAMPUS	714 S EICKHOFF RD EVANSVILLE, IN 47712

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	are stored, at least two times a day, per CDC Guidelines". 3.1-25(m)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to ensure food was stored appropriately and dishwasher temperatures were within range and completed for 1 of 1 kitchen observations. Food was not labeled correctly, left open to air, and expired food was not disposed of from the refrigerator and the freezer. Dishwasher final wash temperatures documented in logs were not at an appropriate level. (Kitchen)	F 0812	**Failure to have properly labeling, dating, and cleaning of foods and beverages in the kitchen and pantry areas. All foods and beverages have been discarded that were not properly labeled or dated. The kitchen and pantries have been cleaned. Temperature log for the dishwashing machine was**	06/09/2023

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	Findings include: On 5/9/23 at 8:49 A.M., the following was observed in the kitchen: Dry storage: An opened bag of pasta without a label and open to air Boxes containing food on the floor Freezer: An opened bag of peas with a prep (preparation/open) date of 4/11/23 and open to air An opened bag of broccoli with handwritten date of 5/4 (no year) 7 small bowls of vanilla ice cream on a tray without a label An open bag of onion rings without a label and open to air Unknown food item in brown bag without label and open to air Boxes containing food items on the floor Refrigerator: Poppy seed dressing out of original container with a use by date of 5/8/23 White dressing out of original container without a label Honey mustard dressing out of original container with a use by date of 5/7/23 Tub of sour cream with manufacturer's use by date of 5/7/23 Diced potatoes in a bag open to air Shredded potatoes in a bag labeled "pot 5/8/23" and open to air Ground meat without a label and open to air Strawberries in a container with fuzzy white substance covering them An opened bag of Swiss cheese slices with a use by date of 5/7 (no year indicated)		**not filled out completely. There were no residents affected by the alleged deficient practice and through corrective actions will prevent further recurrence of monitoring of dishwasher temperatures.** **All residents have the potential to be affected by this. All foods and beverages have been discarded that were not properly labeled or dated. The kitchen and pantries have been cleaned. Culinary staff will be in educated on the procedures and expectations regarding the dishwasher temperatures and logging of temperatures, logging food temperatures, and policy and procedure related to food storage.** **The Director of Food Services or designee will conduct random audits of food storage to ensure that food is stored and labeled in a safe and sanitary manner. Audits will be completed 5 times a week x 4 weeks, weekly x 4 weeks, every other week x 4 weeks, and then monthly for 3 months. Director of Food Service/designee will monitor and/or verify dishwasher wash temps reach 150 degrees and rinse cycle reaches 180 degrees; as well as monitoring of dishwasher temperature log to ensure it is filled out. Audits**	

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	An opened bag of American cheese slices with received date of 5/1/23 Walk in refrigerator (HCR3): A drink pitcher containing brown liquid without a label A box of nectar cranberry juice with a use by date of 5/5/23 and manufacturer's expiration date of 3/29/23 A box of nectar cranberry juice with a use by date of 5/9/23 and manufacturer's expiration date of 5/4/23 A drink pitcher of sweet tea with use by date of 5/7/23 A drink pitcher containing clear liquid without a label A drink pitcher of root beer with a use by date of 5/8/23 During an interview on 5/9/23 at 9:34 A.M., Kitchen Staff 2 indicated they did the dishes that morning and at that time indicated they were not sure if the black lines drawn on the gauges were to indicate what temperature the dishwasher must reach for the rinse and final wash. On 5/9/23 at 9:35 A.M., the dishwasher temperature gauges were observed to be at a high level and filled with water splotches which made the gauges hard to read. At that time, the Kitchen Manager indicated the wash temperature should be at least 160 degrees Fahrenheit and the final rinse should be at least 180 degrees Fahrenheit, the gauges were hard to read, they did not have another method to check the temperatures, and they may need to call [company name] that does maintenance on the machine to have them come look at it. On 5/9/23 at 10:05 A.M., the log book with		**will be completed 5 times a week x 4 weeks, weekly x 4 weeks, every other week x 4 weeks, and then monthly for 3 months.** **As a quality measure, the DFS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months, if needed, until 100% compliance met.**	

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	dishwasher temperatures was provided by the Kitchen Manager and they indicated kitchen staff should be documenting the dishwasher temperatures for the rinse and final wash three times every day. The dishwasher temperature log was reviewed from 4/5/23 to 5/9/23 and indicated the following: 4/5/23 breakfast final rinse temperature was 170 4/5/23 noon meal final rinse temperature was 175 4/5/23 evening meal final rinse temperature was 175 4/6/23 breakfast final rinse temperature was 170 4/6/23 noon meal final rinse temperature was 171 The wash and final rinse temperatures were not filled in for the evening meal on 4/6/23. 4/7/23 breakfast final rinse temperature was 170 4/7/23 noon meal final rinse temperature was 175 The wash and final rinse temperatures were not filled in for the evening meal on 4/7/23. 4/8/23 breakfast final rinse temperature was 170 4/8/23 noon meal final rinse temperature was 175 4/8/23 evening meal final rinse temperature was 172 4/9/23 breakfast final rinse temperature was 170 4/9/23 noon meal final rinse temperature was 170 The wash and final rinse temperatures were not filled in for the evening meal on 4/9/23. 4/10/23 breakfast final rinse temperature was 170 4/10/23 noon meal final rinse temperature was 175 The wash and final rinse temperatures were not filled in for the evening meal on 4/10/23. 4/11/23 breakfast final rinse temperature was 170 4/11/23 noon meal final rinse temperature was 175 4/11/23 evening meal final rinse temperature was 170 4/12/23 breakfast final rinse temperature was 170 4/12/23 noon meal final rinse temperature was 175 The wash and final rinse temperatures were not filled in for the evening meal on 4/12/23.			

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	There was not a log included for the date of 4/13/23 4/14/23 breakfast final rinse temperature was 170 4/14/23 noon meal final rinse temperature was 175 The wash and final rinse temperatures were not filled in for the evening meal on 4/14/23. 4/15/23 breakfast final rinse temperature was 170 4/15/23 noon meal final rinse temperature was 172 4/15/23 evening meal final rinse temperature was 180 The wash and final rinse temperatures were not filled in for breakfast or noon meals on 4/16/23. 4/16/23 evening meal final rinse temperature was 190 4/17/23 breakfast final rinse temperature was 175 4/17/23 noon meal final rinse temperature was 175 4/17/23 evening meal final rinse temperature was 175 The wash and final rinse temperatures were not filled in for breakfast or noon meals on 4/18/23. 4/18/23 evening meal final rinse temperature was 170 4/19/23 breakfast final rinse temperature was 170 4/19/23 noon meal final rinse temperature was 171 The wash and final rinse temperatures were not legible for the evening meal on 4/19/23. 4/20/23 breakfast final rinse temperature was 170 4/20/23 noon meal final rinse temperature was 175 4/20/23 evening meal final rinse temperature was 175 4/21/23 breakfast final rinse temperature was 175 4/21/23 noon meal final rinse temperature was 175 4/21/23 evening meal final rinse temperature was 180 4/22/23 breakfast final rinse temperature was 175 4/22/23 noon meal final rinse temperature was 175 4/22/23 evening meal final rinse temperature was 180 4/23/23 breakfast final rinse temperature was 170 4/23/23 noon meal final rinse temperature was 173			

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	The wash and final rinse temperatures were not legible for the evening meal on 4/23/23. The wash and final rinse temperatures were not filled in for breakfast, noon meal, or evening meal on 4/24/23. 4/25/23 breakfast final rinse temperature was 170 4/25/23 noon meal final rinse temperature was 175 4/25/23 evening meal final rinse temperature was 170 4/26/23 breakfast final rinse temperature was 170 4/26/23 noon meal final rinse temperature was 175 The wash and final rinse temperatures were not legible for the evening meal on 4/26/23. 4/27/23 breakfast final rinse temperature was 170 4/27/23 noon meal final rinse temperature was 172 The wash and final rinse temperatures were not legible for the evening meal on 4/27/23. 4/28/23 breakfast final rinse temperature was 170 4/28/23 noon meal final rinse temperature was 175 The wash and final rinse temperatures were not filled in for the evening meal on 4/28/23. 4/29/23 breakfast final rinse temperature was 170 4/29/23 noon meal final rinse temperature was 175 The wash and final rinse temperatures were not filled in for the evening meal on 4/29/23. There was not a log included for the date of 4/30/23 5/1/23 breakfast final rinse temperature was 170 5/1/23 noon meal final rinse temperature was 175 The wash and final rinse temperatures were not legible for the evening meal on 5/1/23. 5/2/23 breakfast final rinse temperature was 170 5/2/23 noon meal final rinse temperature was 175 The wash and final rinse temperatures were not legible for the evening meal on 5/2/23. 5/3/23 breakfast final rinse temperature was 170 5/3/23 noon meal final rinse temperature was 175 The wash and final rinse temperatures were not filled in for the evening meal on 5/3/23. 5/4/23 breakfast final rinse temperature was 175			

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	5/4/23 noon meal final rinse temperature was 175 5/4/23 evening meal final rinse temperature was 180 5/5/23 breakfast final rinse temperature was 172 5/5/23 noon meal final rinse temperature was 175 5/5/23 evening meal final rinse temperature was 180 There was not a log included for the date of 5/6/23 5/7/23 breakfast final rinse temperature was 171 5/7/23 noon meal final rinse temperature was 170 5/7/23 evening meal final rinse temperature was 180 5/8/23 breakfast final rinse temperature was 170 The wash and final rinse temperatures were not filled in for the noon and evening meals on 5/8/23. 5/9/23 breakfast final rinse temperature was 172 During an interview on 5/9/23 at 10:14 A.M., the Regional Consultant indicated there were not any residents in the facility with communicable diseases or gastrointestinal upset. On 5/12/23 at 11:15 A.M., the following was observed in the kitchen: Freezer: An opened bag of peas with a prep (preparation/open) date of 4/11/23 and open to air Refrigerator: Strawberries in a container with fuzzy white substance covering them During an interview on 5/15/23 at 8:37 A.M., the Kitchen Manager indicated there should be a received label placed on items when they are received. Once the item is opened, it should have a label placed on it that includes the item description, date opened, and expiration date but "the labels are confusing and it's such a waste of product". They further indicated that staff should			

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	check at the end of their shift for sealed bags and they should check twice daily for labels that may have fallen off and expired products. Moldy foods should be discarded. They further indicated in regards to the dishwasher temperature logs, they do not feel like they need to be filled out as the form indicates because while staff is doing dishes, they should be monitoring the temperatures to make sure they are high enough while the dishwasher is going. There was not an investigation into the lower recorded temperatures. The gauges on the machine have been changed by [company name] because they were so difficult to read. A current Food Labeling policy, revised 4/26/22, provided by the Regional Consultant on 5/15/23 at 10:30 A.M., indicated " ... When a food item enters the facility, the item needs to be labeled with a received-on label before it is put away ... Foods in production need BOTH a production date AND a use by date. Foods are considered to be in production when they have been taken out of the original container AND the seal has been broken ... handwritten labels must include: item name, date and time the food was labeled, use by date, initials of staff member ...all food items must be properly covered (not exposed to air) prior to being labeled and dated ...". The [name of dishwasher] manual, Rev 2.01A, was reviewed and indicated " ... After the machine has warmed up for five to ten minutes (5 - 10 min.), observe the wash and rinse temperatures. The wash temperature must be 155 degrees F (Fahrenheit) minimum. The rinse temperature must be 180 degrees F minimum". A current Dish Machine policy, revised 11/22/2017, provided by the Regional Consultant			

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	on 5/15/23 at 10:30 A.M., indicated " ... High-Temperature Dishwasher (heat sanitization) recommended guideline: wash 150-165 degrees F, final rinse 180 degrees F ... ". On 5/15/23 at 10:41 A.M., a current Dishwasher Temperature Log policy was asked for from the Regional Consultant; however, they indicated they were not sure there was one and one was not provided. 3.1-21(i)(2) 3.1-21(i)(3)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: May 9, 10, 11, 12, 15, 2023 Facility number: 012448 Residential Census: 52 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	The submission of this plan of correction does not indicate an admission by West River Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of West River Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	

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			Corrections to be completed by **6/9/23**.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (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: (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 the fire department was invited to attend fire drills at least every 6 months. Finding includes: On 5/12/23 at 2:10 P.M., fire drill reports were provided for 2022 and 2023. The drill reports lacked documentation of the fire department being invited or attending the fire drills. At that time, the	R 0092	1. No residents were affected by the alleged deficient practice. The Director of Plant Operations and the Executive Director immediately educated on inviting the fire department to a fire drill every 6 months. The fire department has been invited to attend the next fire drill. 2. All residents have the	06/09/2023

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	Maintenance Supervisor indicated he was aware the fire department should be invited to attend fire drills every 6 months but was unaware of invitations being extended and was unable to produce documentation showing the fire department had been invited to attend. On 5/15/23 at 1:27 P.M., a Fire Drills Policy was provided, dated 9/13/18. It lacked requirements on fire department invitation or participation in facility fire drills.		potential to be affected. The IDT (interdisciplinary team) educated on the regulation of inviting the fire department to a fire drill every 6 months. 3. As measure of ongoing compliance, the Executive Director or designee will monitor the fire department attendance at the facility's fire drill weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months, if needed, until 100% compliance met.	
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to ensure semi-annual evaluations were completed or signed by the resident or responsible party for 2 of 5 residents reviewed (Resident 3, Resident 4).	R 0214	1. Resident #3 was assessed, and no adverse effects noted from alleged deficiency. Service plan completed for Resident #3. 2. All residents have the	06/09/2023

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	Findings include: 1. On 5/12/23 at 12:35 P.M., Resident 3's clinical record was reviewed. The most recent semi-annual evaluation was dated 12/8/21. 2. On 5/12/23 at 12:30 P.M., Resident 4's clinical record was reviewed. The most recent semi-annual evaluation was dated 3/7/22. During an interview on 5/15/23 at 9:51 A.M., the Regional Consultant indicated semi-annual evaluations should be completed every 6 months. On 5/15/23 at 9:55 A.M., a current assisted living evaluation and service plan guidelines policy, dated 12/11/2017, was provided and indicated "...Upon admission, semi-annually and with significant change in health status or functioning, the licensed nurse shall evaluate the resident's physical, mental, psychosocial functioning and care needs...".		potential to be affected by the alleged deficiency. DHS/designee will audit to establish a baseline of all service plans that are due or past due. DHS/designee to schedule service plans to be completed for those residents that are due or past due. Clinical staff educated on Evaluation and Service Plan Guidelines policy and procedure. 3. As a measure of ongoing compliance, the DHS or designee will audit Service Plans to ensure timely completion. Audit to consist of 5 random residents weekly x4 weeks, then 5 random residents every other week for 2 months, then 5 random residents monthly for 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months, if needed, until 100% compliance met.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following:			

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	155785	A. BUILDING 00 B. WING	05/15/2023

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	(1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, interview, and record review, the facility failed to ensure residents that were self administering medications were assessed for capability to self administer medications for 1 of 3 residents observed for accidents (Resident 4). Finding includes: During an observation on 5/15/23 at 11:38 A.M., Licensed Practical Nurse (LPN) 9 dispensed Resident 4's medication. At that time, Resident 4 was at an activity and requested that LPN 9 leave the medication in her room. LPN 9 entered Resident 4's room and placed the medications on the counter. During an observation on 5/15/23 at 11:47 A.M., Resident 4 was walking in the hallway and the paper cup with 3 pills was observed sitting on the seat of the resident's walker. During an observation on 5/15/23 at 12:11 P.M., Resident 4 was observed sitting at the dining room table eating. At that time, the paper medication cup was empty. On 5/15/23 at 12:20 P.M., Resident 4's clinical record was reviewed. The record lacked a self-administration order.	R 0216	1. Resident #4 was assessed and resident able to self-administration medications, but facility staff will administer. Resident assessed and no affects noted from the alleged deficient practice. 2. All residents have the potential to be affected from the alleged deficient practice. All residents requesting to self-administer medications have completed self-administration assessments to validate competency. All identified residents were verified to have care plans in place for self-administration. Nursing staff have been provided education regarding medication administration, self-administration, assessments, and care planning. 3. As a measure of ongoing compliance, the DHS or designee will audit/observe adherence to medication administration policy for self-administration. Audit to consist of 5 residents weekly x4 weeks, then 5 residents every other week for 2 months, then 5	06/09/2023

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	During an interview on 5/15/23 at 1:50 P.M., the Regional Consultant indicated that nursing staff should be present when Resident 4 receives medication. On 5/15/23 at 1:27 P.M., a current guidelines for Self Administration of Medications policy, dated 5/22/2018, was provided and indicated "Residents requesting to self-medicate or has self-medication as a part of their plan of care shall be assessed using the observation [name of corporation] Self Administration of Medication within the electronic health record. Results of the assessment will be presented to the physician for evaluation and an order for self-medication...".		residents monthly for 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months, if needed, until 100% compliance met.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (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: (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.			

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	(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 service plans were completed or signed by the resident or responsible party for 2 of 5 residents reviewed (Resident 3, Resident 4). Findings include: 1. On 5/12/23 at 12:35 P.M., Resident 3's clinical record was reviewed. The most recent service plan was dated 12/8/21. 2. On 5/12/23 at 12:30 P.M., Resident 4's clinical record was reviewed. The most recent service plan was dated 3/7/22. During an interview on 5/15/23 at 9:51 A.M., the Regional Consultant indicated service plans should be completed every 6 months. On 5/15/23 at 9:55 A.M., a current assisted living evaluation and service plan guidelines policy, dated 12/11/2017, was provided and indicated "...A service plan shall be identified and implemented in response to the resident's evaluation and in collaboration with the resident and/or responsible party...".	R 0217	1. Resident #3 was assessed, and no adverse effects noted from alleged deficiency. Service plan completed for Resident #3. 2. All residents have the potential to be affected by the alleged deficiency. DHS/designee will audit to establish a baseline of all service plans that are due or past due. DHS/designee to schedule service plans to be completed for those residents that are due or past due. Clinical staff educated on Evaluation and Service Plan Guidelines. 3. As a measure of ongoing compliance, the DHS or designee will audit Service Plans to ensure timely completion. Audit to consist of 5 random residents weekly x4 weeks, then 5 random residents every other week for 2 months, then 5 random residents monthly for 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance	06/09/2023

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			Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months, if needed, until 100% compliance met.	
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 and interview, the facility failed to ensure food was stored appropriately and dishwasher temperatures were within range and completed for 1 of 1 kitchen observations. Food was not labeled correctly, left open to air, and expired food was not disposed of from the refrigerator and the freezer. Dishwasher final wash temperatures documented in logs were not at an appropriate level. (Kitchen) Findings include: On 5/9/23 at 8:49 A.M., the following was observed in the kitchen: Dry storage: An opened bag of pasta without a label and open to air Boxes containing food on the floor Freezer: An opened bag of peas with a prep (preparation/open) date of 4/11/23 and open to air An opened bag of broccoli with handwritten date of 5/4 (no year) 7 small bowls of vanilla ice cream on a tray without a label	R 0273	=”” a=””> **Failure to have properly labeling, dating, and cleaning of foods and beverages in the kitchen and pantry areas. All foods and beverages have been discarded that were not properly labeled or dated. The kitchen and pantries have been cleaned. Temperature log for the dishwashing machine was not filled out completely. There were no residents affected by the alleged deficient practice and through corrective actions will prevent further recurrence of monitoring of dishwasher temperatures.** **All residents have the potential to be affected by this. All foods and beverages have been discarded that were not properly labeled or dated. The kitchen and pantries have been cleaned. Culinary staff will be in educated on the procedures and expectations regarding the**	06/09/2023

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	An open bag of onion rings without a label and open to air Unknown food item in brown bag without label and open to air Boxes containing food items on the floor Refrigerator: Poppy seed dressing out of original container with a use by date of 5/8/23 White dressing out of original container without a label Honey mustard dressing out of original container with a use by date of 5/7/23 Tub of sour cream with manufacturer's use by date of 5/7/23 Diced potatoes in a bag open to air Shredded potatoes in a bag labeled "pot 5/8/23" and open to air Ground meat without a label and open to air Strawberries in a container with fuzzy white substance covering them An opened bag of Swiss cheese slices with a use by date of 5/7 (no year indicated) An opened bag of American cheese slices with received date of 5/1/23 Walk in refrigerator (HCR3): A drink pitcher containing brown liquid without a label A box of nectar cranberry juice with a use by date of 5/5/23 and manufacturer's expiration date of 3/29/23 A box of nectar cranberry juice with a use by date of 5/9/23 and manufacturer's expiration date of 5/4/23 A drink pitcher of sweet tea with use by date of 5/7/23 A drink pitcher containing clear liquid without a label A drink pitcher of root beer with a use by date of		**dishwasher temperatures and logging of temperatures, logging food temperatures, and policy and procedure related to food storage.** **The Director of Food Services or designee will conduct random audits of food storage to ensure that food is stored and labeled in a safe and sanitary manner. Audits will be completed 5 times a week x 4 weeks, weekly x 4 weeks, every other week x 4 weeks, and then monthly for 3 months. Director of Food Service/designee will monitor and/or verify dishwasher wash temps reach 150 degrees and rinse cycle reaches 180 degrees; as well as monitoring of dishwasher temperature log to ensure it is filled out. Audits will be completed 5 times a week x 4 weeks, weekly x 4 weeks, every other week x 4 weeks, and then monthly for 3 months.** **As a quality measure, the DFS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.**	

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	5/8/23 Juice machine in dining room: Thick, sticky, brown substance where orange juice spout came out of machine On 5/9/23 at 9:34 A.M., Kitchen Staff 2 indicated they did the dishes that morning and at that time indicated they were not sure if the black lines drawn on the gauges were to indicate what temperature the dishwasher must reach for the rinse and final wash. On 5/9/23 at 9:35 A.M., the dishwasher temperature gauges were observed to be at a high level and filled with water splotches which made the gauges hard to read. At that time, the Kitchen Manager indicated the wash temperature should be at least 160 degrees Fahrenheit and the final rinse should be at least 180 degrees Fahrenheit, the gauges were hard to read, they did not have another method to check the temperatures, and they may need to call [company name] that does maintenance on the machine to have them come look at it. On 5/9/23 at 10:05 A.M., the log book with dishwasher temperatures was provided by the Kitchen Manager and they indicated kitchen staff should be documenting the dishwasher temperatures for the rinse and final wash three times every day. The dishwasher temperature log was reviewed from 4/5/23 to 5/9/23 and indicated the following: 4/5/23 breakfast final rinse temperature was 170 4/5/23 noon meal final rinse temperature was 175 4/5/23 evening meal final rinse temperature was 175 4/6/23 breakfast final rinse temperature was 170		**Ongoing monitoring will continue past 6 months, if needed, until 100% compliance met.**	

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	4/6/23 noon meal final rinse temperature was 171 The wash and final rinse temperatures were not filled in for the evening meal on 4/6/23. 4/7/23 breakfast final rinse temperature was 170 4/7/23 noon meal final rinse temperature was 175 The wash and final rinse temperatures were not filled in for the evening meal on 4/7/23. 4/8/23 breakfast final rinse temperature was 170 4/8/23 noon meal final rinse temperature was 175 4/8/23 evening meal final rinse temperature was 172 4/9/23 breakfast final rinse temperature was 170 4/9/23 noon meal final rinse temperature was 170 The wash and final rinse temperatures were not filled in for the evening meal on 4/9/23. 4/10/23 breakfast final rinse temperature was 170 4/10/23 noon meal final rinse temperature was 175 The wash and final rinse temperatures were not filled in for the evening meal on 4/10/23. 4/11/23 breakfast final rinse temperature was 170 4/11/23 noon meal final rinse temperature was 175 4/11/23 evening meal final rinse temperature was 170 4/12/23 breakfast final rinse temperature was 170 4/12/23 noon meal final rinse temperature was 175 The wash and final rinse temperatures were not filled in for the evening meal on 4/12/23. There was not a log included for the date of 4/13/23. 4/14/23 breakfast final rinse temperature was 170 4/14/23 noon meal final rinse temperature was 175 The wash and final rinse temperatures were not filled in for the evening meal on 4/14/23. 4/15/23 breakfast final rinse temperature was 170 4/15/23 noon meal final rinse temperature was 172 4/15/23 evening meal final rinse temperature was 180 The wash and final rinse temperatures were not filled in for breakfast or noon meals on 4/16/23. 4/16/23 evening meal final rinse temperature was			

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	190 4/17/23 breakfast final rinse temperature was 175 4/17/23 noon meal final rinse temperature was 175 4/17/23 evening meal final rinse temperature was 175 The wash and final rinse temperatures were not filled in for breakfast or noon meals on 4/18/23. 4/18/23 evening meal final rinse temperature was 170 4/19/23 breakfast final rinse temperature was 170 4/19/23 noon meal final rinse temperature was 171 The wash and final rinse temperatures were not legible for the evening meal on 4/19/23. 4/20/23 breakfast final rinse temperature was 170 4/20/23 noon meal final rinse temperature was 175 4/20/23 evening meal final rinse temperature was 175 4/21/23 breakfast final rinse temperature was 175 4/21/23 noon meal final rinse temperature was 175 4/21/23 evening meal final rinse temperature was 180 4/22/23 breakfast final rinse temperature was 175 4/22/23 noon meal final rinse temperature was 175 4/22/23 evening meal final rinse temperature was 180 4/23/23 breakfast final rinse temperature was 170 4/23/23 noon meal final rinse temperature was 173 The wash and final rinse temperatures were not legible for the evening meal on 4/23/23. The wash and final rinse temperatures were not filled in for breakfast, noon meal, or evening meal on 4/24/23. 4/25/23 breakfast final rinse temperature was 170 4/25/23 noon meal final rinse temperature was 175 4/25/23 evening meal final rinse temperature was 170 4/26/23 breakfast final rinse temperature was 170 4/26/23 noon meal final rinse temperature was 175 The wash and final rinse temperatures were not legible for the evening meal on 4/26/23.			

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	4/27/23 breakfast final rinse temperature was 170 4/27/23 noon meal final rinse temperature was 172 The wash and final rinse temperatures were not legible for the evening meal on 4/27/23. 4/28/23 breakfast final rinse temperature was 170 4/28/23 noon meal final rinse temperature was 175 The wash and final rinse temperatures were not filled in for the evening meal on 4/28/23. 4/29/23 breakfast final rinse temperature was 170 4/29/23 noon meal final rinse temperature was 175 The wash and final rinse temperatures were not filled in for the evening meal on 4/29/23. There was not a log included for the date of 4/30/23. 5/1/23 breakfast final rinse temperature was 170 5/1/23 noon meal final rinse temperature was 175 The wash and final rinse temperatures were not legible for the evening meal on 5/1/23. 5/2/23 breakfast final rinse temperature was 170 5/2/23 noon meal final rinse temperature was 175 The wash and final rinse temperatures were not legible for the evening meal on 5/2/23. 5/3/23 breakfast final rinse temperature was 170 5/3/23 noon meal final rinse temperature was 175 The wash and final rinse temperatures were not filled in for the evening meal on 5/3/23. 5/4/23 breakfast final rinse temperature was 175 5/4/23 noon meal final rinse temperature was 175 5/4/23 evening meal final rinse temperature was 180 5/5/23 breakfast final rinse temperature was 172 5/5/23 noon meal final rinse temperature was 175 5/5/23 evening meal final rinse temperature was 180 There was not a log included for the date of 5/6/23. 5/7/23 breakfast final rinse temperature was 171 5/7/23 noon meal final rinse temperature was 170 5/7/23 evening meal final rinse temperature was 180			

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	5/8/23 breakfast final rinse temperature was 170 The wash and final rinse temperatures were not filled in for the noon and evening meals on 5/8/23. 5/9/23 breakfast final rinse temperature was 172 On 5/9/23 at 10:14 A.M., the Regional Consultant indicated there were no residents in the facility with communicable diseases or gastrointestinal upset. On 5/12/23 at 11:15 A.M., the following was observed in the kitchen: Freezer: An opened bag of peas with a prep (preparation/open) date of 4/11/23 and open to air Refrigerator: Strawberries in a container with fuzzy white substance covering them On 5/15/23 at 8:37 A.M., the Kitchen Manager indicated there should be a received label placed on items when they are received. Once the item is opened, it should have a label placed on it that includes the item description, date opened, and expiration date but "the labels are confusing and it's such a waste of product". They further indicated that staff should check at the end of their shift for sealed bags and they should check twice daily for labels that may have fallen off and expired products. Moldy foods should be discarded. The kitchen staff should wipe off the juice machine nozzles and juice boxes inside and dump out the drip trays after each meal when they are done doing dishes. They further indicated in regards to the dishwasher temperature logs, they do not feel like they need to be filled out as the form indicates because while staff is doing dishes, they should be monitoring the temperatures to make sure they are high enough while the dishwasher is going. There was not an			

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	investigation into the lower recorded temperatures. The gauges on the machine have been changed by [company name] because they were so difficult to read. A current Food Labeling policy, revised 4/26/22, provided by the Regional Consultant on 5/15/23 at 10:30 A.M., indicated " ... When a food item enters the facility, the item needs to be labeled with a received-on label before it is put away ... Foods in production need BOTH a production date AND a use by date. Foods are considered to be in production when they have been taken out of the original container AND the seal has been broken ... handwritten labels must include: item name, date and time the food was labeled, use by date, initials of staff member ...all food items must be properly covered (not exposed to air) prior to being labeled and dated ...". The [name of dishwasher] manual, Rev 2.01A, was reviewed and indicated " ... After the machine has warmed up for five to ten minutes (5 - 10 min.), observe the wash and rinse temperatures. The wash temperature must be 155 degrees F (Fahrenheit) minimum. The rinse temperature must be 180 degrees F minimum". A current Dish Machine policy, revised 11/22/2017, provided by the Regional Consultant on 5/15/23 at 10:30 A.M., indicated " ... High-Temperature Dishwasher (heat sanitization) recommended guideline: wash 150-165 degrees F, final rinse 180 degrees F ... ". On 5/15/23 at 10:41 A.M., a current Dishwasher Temperature Log policy was asked for from the Regional Consultant; however, she was not sure there was one and one was not provided.			