STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155735	A. BUILDING 00 B. WING	01/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASHFORD PLACE HEALTH CAMPUS	2200 N RILEY HWY SHELBYVILLE, IN 46176

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: January 22, 23, 24, 25, 28, and 29, 2019. Facility number: 004268 Provider number: 155735 AIM number: 200504460 Census bed type: SNF: 19 SNF/NF: 34 Residential: 29 Total: 82 Census payor type: Medicare: 6 Medicaid: 30 Other: 17 Total: 53 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 4, 2019	F 0000	**Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during Recertification and Complaint visit with exit on January 29, 2019. Please accept this plan of correction as the provider's credible allegation of compliance as of February 18, 2019. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.**	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each			

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

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	resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on observation, interview, and record review, the facility failed to ensure dignity was maintained for 1 of 3 residents randomly observed at a dining table in the cafe dining room and 1 of 1 resident reviewed for urinary catheters. (Residents 6 and 207)	F 0550	1. Resident # 6 and #207 had no adverse effects noted, Social Services will continue to follow up as needed. 2. All residents in the Health Care Center that have a Foley Catheter and/or need assistance	02/18/2019

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	Findings include: 1. The clinical record for Resident 6 was reviewed on 1/27/19 at 10:00 a.m. The diagnosis for Resident 6 included, but was not limited to, aphasia. A quarterly MDS (Minimum Data Set) assessment dated 11/4/18, indicated Resident 6 was extensive assistance with 1 staff person for eating. During a dining observation in the cafe dining room on 1/22/19 at 12:24 p.m., Certified Resident Care Associate (CRCA) 6 was observed sitting down at Resident 6's table and started to assist Resident 6 with eating her lunch meal. During that time, CRCA 6 had stopped assisting Resident 6 and indicated to her she would be back. CRCA 6 was observed getting up from the table and pushing Resident 107's wheelchair out of the dining room. During that time, Resident 6 was sitting at the table with her lunch meal with no assistance. CRCA 6 returned back to the dining room 2 minutes later and sat back down with Resident 6 continuing to feed her. She then stopped assisting her and left the table. CRCA 6 was observed going into the kitchen and returned with a cookie for Resident 6's tablemate Resident 10. She then sat back down at the table and continued to give bites of food to Resident 6. After 5 minutes of assistance, CRCA 6 stopped and had gotten up from the table. She was observed leaving the dining room with Resident 10. She then returned back to the dining room and was observed giving more bites to Resident 6. An interview was conducted with the Assistant Director of Nursing Services on 1/24/19 at 3:10 p.m. She indicated the staff should not leave the table while assisting a resident with eating until he		with eating have the potential to be effected by the alleged deficient practice. Director of Health Services and/or Designee will conduct an audit on residents in the Health Care Center to identify resident's that have a Foley Catheter and/or need assistance with eating. The Director of Health Services and/or Designee will complete an in-service with nursing staff on Resident Rights related to Foley Catheter care and assisting residents with eating. 3. As a measure of ongoing compliance, The Director of Health Services or Designee will complete an audit to include five residents, said audit will be three times weekly for 30 days, then weekly for 30 days, then monthly x 1, then ongoing as needed. 4. For quality assurance, Director of Health Services and/or Designee will review any findings, and subsequent corrective actions. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted.	

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	or she was finished. A Resident Rights Guidelines policy was provided by Nurse Consultant 1 on 1/28/19 at 10:06 a.m. It indicated "...Purpose. To ensure resident rights are respected and protected and provided an environment in which they can be exercised...Procedures. 1. Residents shall not leave their individual personalities or basic human rights behind when they move to a health campus. The following is a list of rights by staff at (name of company): 2. Our residents have a right to.... a. Be treated with dignity and respect...f. be treated fairly, courteously and with respect by all staff.." 2. The clinical record for Resident 207 was reviewed on 1/23/2019 at 3:00 p.m. The diagnosis for Resident 207 included, but were not limited to, urinary tract infection and retention of urine. On 1/28/2019 at 12:08 p.m. QMA (Qualified Medication Aide) 5 was observed providing catheter care for Resident 207. She entered Resident 207's room and informed him that she was going to perform catheter care for him. Resident 207 was lying in bed under a blanket. She pulled the privacy curtain to the corner of the track, leaving the privacy curtain open to one side of the room. The door to the room was ajar. The blinds on the window were open, with a sidewalk and home, visible through the window of Resident 207's room. QMA 5 put on a pair of disposable gloves, and removed the blanket covering Resident 207. She pulled his sweat pants down to his knees and then unfastened and opened his incontinence garment, exposing his genitalia. She then left the bedside and removed her disposable gloves. She washed her hands and obtained a basin of warm water from the bathroom, which was visible from			

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	the bed. She then returned to the bed side. She put on a clean pair of disposable gloves and proceeded to perform catheter care for Resident 207. The blinds on the window in the room remained open, with the side walk and home visible through the window. The door to the room remained open. QMA 5 finished performing catheter care and then reapplied Resident 207's incontinent garment and pulled up his pants. During an interview on 1/28/2019 at 12:15 p.m., QMA 5 indicated that she should have closed the door to the room and the blinds on the window prior to performing catheter care for Resident 207. On 1/25/2019 at 2:10 p.m., Consultant 1 provided a current copy of the Urinary Catheter Care Standard Operational Procedure, with an effective date of 5/11/2016. The procedure read as follows: "Overview To prevent infections of the resident's urinary tract. SOP Details...19. Prior to beginning the procedure ... d. Close the room entrance door. e. pull the privacy curtain. f. close drapes/ lower shades/ close blinds, as applicable..." 3.1-3(a)			
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 charged; (B) Those other items and services that the facility offers and for which the resident may			

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	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 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			

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	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 issue a SNFABN (Skilled Nursing Facility Advance Beneficiary Notice) to 1 of 3 residents reviewed for liability and appeal notices. (Resident 4) Findings include: On 1/24/19 at 11:00 a.m., the SSD provided the completed Beneficiary Notice - Residents Discharged Within the Last Six Months worksheet. It indicated Resident 4 discharged from a Medicare covered Part A stay with benefit days remaining on 10/20/19, and remained in the facility. The NOMNC (Notice of Medicare Non Coverage) for Resident 4 was provided by the SSD (Social Services Director) on 1/24/19 at 11:00 a.m. No SNFABN was provided by the SSD. The NOMNC indicated services would end on 10/19/18. The NOMNC was signed by Resident 4 on 11/14/18. An interview was conducted with the SSD on 1/24/19 at 11:14 a.m. She indicated a SNFABN was not provided to Resident 4, but one should have been issued. The NOMNC Standard Operating Procedure was provided by the SSD on 1/24/19 at 12:03 p.m. It indicated a SNFABN notice was required when, "Part A Stay will end because: Provider determines that beneficiary no longer requires daily, skilled services. Beneficiary will not be receiving therapy or other part B services, resident will remain in facility (custodial.)"	F 0582	1. Resident # 4 identified, Social Service Director met with resident and/or responsible party to review ABN notice. 2. All Part A residents in the Health Care Center that will no longer have a daily skilled need have the potential to be effected by the alleged practice.The Director of Health Services and/or Designee will conduct an audit of Part A residents to identify those no longer requiring a daily skilled need to ensure ABN is provided. The Director of Health Services and/or Designee will complete an in-service with Social Service Director on ABN policy/procedure. 3. As a measure of ongoing compliance, The Director of Health Services and/or Designee will complete an audit on up to five residents, said audit will be three times weekly for 30 days, then weekly for 30 days, then monthly x 1, then ongoing as needed. 4. For quality assurance, Director of Health Services and/or Designee will review any findings, and subsequent corrective actions. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted.	02/18/2019

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	3.1-4(f)(3)			
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:			

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	(i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. Based on interview and record review the facility failed to assure the accuracy of a baseline care plan for 1 of 1 resident reviewed for urinary catheters. (Resident 207) Findings include: The clinical record for Resident 207 was reviewed on 1/23/2019 at 3:00 p.m. The diagnosis for Resident 207 included, but were not limited to, urinary tract infection and retention of urine. The clinical record contained a discharge summary from the hospital dated 12/26/2018 at 9:31 a.m. The discharge summary indicated that Resident 207 was treated for a urinary tract infection during his hospitalization and was discharged from the hospital with a urinary catheter in place. A nursing progress note dated 12/26/2018 at 3:58 p.m., indicated that Resident 207 had an anchored urinary catheter present which was patent and draining clear yellow urine. The clinical record contained a baseline care plan form dated 12/27/2018. It indicating that Resident 207's bowel and bladder patterns were within normal limits. It did not indicate that Resident 207 had a urinary catheter in place. The baseline care plan indicated that Resident 207's ADL (Activities	F 0655	1. Resident # 207 was assessed on 1/3/2019. Admission care plan completed addressing the presence of Foley Catheter. 2. All residents admitting to The Health Care Center with a Foley Catheter in place at the time of admission have the potential to be affected by alleged deficient practice.The Assessment Support RN completed an in-service with MDS Coordinator on the accurate coding of Foley Catheter on the baseline care plan. An initial audit was completed on residents admitted since 1/23/2019 to ensure any resident admitted with a Foley Catheter was coded on the baseline care plan. 3. As a measure of ongoing compliance, The Assessment Support RN and\or Designee will audit up to three Baseline Care plans, said audit will be three times weekly for 30 days, then once weekly for 30 days, then monthly x 1, then ongoing as needed. 4. For quality assurance, The Director of Health Services and/or Designee will review any findings,	02/18/2019

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	of Daily Living) were not within normal limits. Aftercare for GI/GU (urinary) incident was not marked. During an interview on 1/25/2019 at 3:10 pm, the Director of Health Services, indicated that the urinary catheter and history of GI/GU incident were not captured on the baseline care plan.		and subsequent corrective actions at least quarterly in the campus quality assurance meeting. The plan will be revised as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.			

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	§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview and record review the facility failed to provide appropriate treatment to prevent urinary tract infections for 1 of 1 resident reviewed for urinary catheter. (Resident 207) Findings include: The clinical record for Resident 207 was reviewed on 1/23/2019 at 3:00 p.m. The diagnosis for Resident 207 included, but were not limited to, urinary tract infection and retention of urine. During an observation on 1/23/2019 at 9:39 a.m., Resident 207 was sitting in a broda chair in his room. The drainage bag for his urinary catheter was hung on the leg rest of the broda chair. The nozzle of the urinary drainage bag was touching the carpet. During an observation on 1/23/2019 at 10:55 a.m., Resident 207 was sitting in a broda chair in his room. A wheeled over bed table was positioned in front of the broda chair. The drainage bag for his urinary catheter was hung on the leg rest of the broda chair. Part of the urinary drainage bag, including the nozzle, were touching the carpet. A wheel of the over bed table was on top of the urinary drainage bag. During an observation on 1/25/2019 at 8:47 a.m., Resident 207 was lying in bed in his room. The	F 0690	1. Resident # 207 was immediately assessed and no adverse effects were noted. 2. All residents that have a Foley Catheter and/or a Foley Catheter with treatments in place for UTI prevention have the potential to be effected. The Director of Health Services and/or Designee will complete an audit of residents in the Health Care Center to identify residents with Foley catheters and any treatments they may have in place for UTI prevention. The Director of Health Services and/or Designee will conduct an in-service with nurses related to appropriate positioning of Foley catheter bag and ensuring treatments in place for UTI prevention are administered 3. As a measure of ongoing compliance, the Director of Health Services or Designee will complete audit of residents with Foley catheters and any preventative treatments they may have in place for UTI prevention,this audit will include up to five residents three times weekly for 30 days, then weekly for 30 days, then monthly x 1,	02/18/2019

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	bed was in a low position. The drainage bag for his urinary catheter was positioned on the bed frame. The urinary drainage bag was touching the carpet on the floor. On 1/25/2019 at 2:10 p.m., Consultant 1 provided a current copy of the Urinary Catheter Care Standard Operational Procedure, with an effective date of 5/11/2016. The procedure read as follows: "Overview to prevent infections of the resident's urinary tract. SOP Details... 11. Be sure the catheter tubing and drainage bag are kept off the floor." The clinical record contained a physician's order dated 12/27/2018 at 12:21 p.m. The physician's order indicated that Resident 207 was to receive oxychlorosene sodium (antiseptic medication to treat localized infections) 500 mg mixed with sodium chloride 0.9% (normal saline) irrigation to the bladder every 3rd day for 3 doses. The MAR (Medication Administration Record) for December 2018 indicated that the oxychlorosene sodium was scheduled to be administered on 12/28/2018 and 12/31/2018 and had not been administered due to the medication being unavailable. The January 2019 MAR indicated that the oxychlorosene sodium was scheduled to be administered on 1/3/2019 and had not been administered due it being discontinued. During an interview on 1 /25/2019 at 3:10 p.m., the Director of Health Services indicated that if a medication is unavailable, the pharmacy should be contacted to send the medication. If the medication is unable to be obtained then the physician should be notified. She indicated that Resident 207 should have received the medication.		then ongoing as needed. 4. For quality assurance, the Director of Health Services and/or Designee will review any findings, and subsequent corrective action at least quarterly in the campus quality assurance meeting. The plan will be revised as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits f no concerns are noted.	

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F 0759 SS=D Bldg. 00	3.1-41(a)(2) 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 a medication error rate of less than 5 percent for 2 of 6 residents observed during medication pass. There were 29 opportunities with 2 errors resulting in a 6.9% medications error rate. Findings include: 1. The clinical record for Resident 2 was reviewed on 1/25/2019 at 10:42 a.m. The diagnosis for Resident 2 included, but were not limited to, heart failure. A physicians order dated 1/10/2019 indicated Resident 2 was to receive Buspirone (antianxiety medication) 5 milligrams 1 time daily. On 1/25/2019 at 8:47 a.m., Licensed Practical Nurse 8 was observed administering medications to Resident 2. She removed a medication bottle from the medication cart with a label reading "Buspirone 5 mg. Give 1/2 tablet [2.5 milligrams] at HS [hour of sleep]". She placed a half tablet (2.5 milligrams) into a medication cup. She then administered the medications to Resident 2. During an interview on 1/25/2019 at 2:30 p.m., Consultant 1 indicated that Buspirone 5 milligrams	F 0759	1. Resident # 2 and # 39 were immediatly assessed and no adverse effects noted. MD was notified and any orders obtained were initiated. 2. All residents in the Health Care Center have the potential to be effected by the alleged practice.The Director of health Services and/or Designee will conduct a medication administration audit(s) on the Health Care Center, if any medication error(s) is identified they will be addressed immediately. The Director of Health Services or Designee will complete education with nurses on Medication administration policy/procedure. 3. As a measure of ongoing compliance, The Director of Health Services and/or Designee will complete an audit on up to three medication administration observations, said audit will be three times weekly for 30 days, then weekly for 30 days, then monthly x 1, then ongoing as needed.	02/18/2019

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	should have been administered. 2. The clinical record for resident 39 was reviewed on 1/24/2019 at 2:30 p.m. The diagnosis for Resident 39 included, but were not limited to, chronic rhinitis (runny nose). A physicians order dated 10/20/2017 indicated Resident 39 was to receive fluticasone (allergy medication) 2 sprays to each nare (nostril) one time daily. On 1/24/2019 at 9:06 a.m., Registered Nurse 9 was observed administering medication to Resident 39. She removed the fluticasone from the medication cart. She put on disposable gloves and addressed Resident 39, indicating she was administering 1 spray of fluticasone into each nostril. She then removed her disposable gloves and placed the fluticasone back into the medication cart. 3.1-48(c)(1)		4. For quality assurance, Director of Health Services and/or Designee will review any findings, and subsequent corrective actions. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted.	
F 0761 SS=D 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			

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	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 expired medications were disposed of in 1 of 1 medication room observed for medication storage, with the potential to affect 1 out of 56 residents residing in the facility. Findings include: On 1/29/2019 at 10:20 a.m., the medication storage room was observed. The refrigerator in the medication storage room contained a medication (bisacodyl Suppositories) which was dispensed from the pharmacy on 12/7/2016. The manufactures expiration date, located on the packaging, was 10/2018. During an interview on 1/29/2019 at 10:30 a.m., the Assistant Director of Health Services indicated that the medication should have been destroyed. 3.1-25(o)	F 0761	1. No residents were identified. Medication identified was immediately disposed of per policy/procedure. 2. All residents in the Health Care Center that have medication kept in the refrigerator have the potential to be effected by the alleged deficient practice. The Director of Health Services and/or Designee will complete an audit in the Health Care Center medications kept in the refrigerator. The Director of Health Services and/or Designee will conduct an in-service with nurses related to disposal of medications related to medications kept in refrigerator. 3. As a measure of ongoing compliance, the Director of Health Services and/or Designee will complete audit of medications kept in the refrigerator, said audit will be three times weekly for 30 days, then weekly for 30 days, then monthly x 1, then ongoing as needed.	02/18/2019

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			4. For quality assurance, the Director of Health Services and/or Designee will review any findings, and subsequent corrective action at least quarterly in the campus quality assurance meeting. The plan will be revised as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted.	
F 0803 SS=C Bldg. 00	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and			

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	§483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. Based on observation, interview, and record review, the facility failed to follow their menu for 4 of 4 residents reviewed for food with the potential to affect all 53 residents in the facility who eat food from the kitchen. (Residents 3, 17, 36, and 56) Findings include: An interview was conducted with Resident 17 on 1/23/19 at 10:07 a.m. He indicated the facility did not always serve what was on the menu, and they often ran out of items. An interview was conducted with Resident 56 on 1/22/19 at 2:46 p.m. She indicated the facility did not serve what was on the menu. Residents never received what they asked for. She indicated the previous night's dinner was supposed to be cole slaw, but they received greens and corn instead. She indicated they often didn't order the correct items or they ran out of items. An interview was conducted with Resident 3 on 1/22/19 at 2:54 p.m. She indicated she did not receive what she ordered at meals, and the food served was different, than what was on the menu. She indicated the kitchen always ran out of items. The 1/14/19 Resident Council notes were provided by the Life Enrichment Director on 1/23/19 at 2:30 p.m. It indicated dining concerns in regards to supplies being ordered for meals and following ticket orders. The 2/24/19 lunch menu provided by the Executive Director on 2/22/19 at 11:00 a.m.	F 0803	1. Resident # 3, # 17, # 36, and # 56 had grievance form completed. 2. All residents in the Health Care Center have the potential to be effected by the alleged deficient practice. The Executive Director and/or Designee will complete an audit(s) on the Health Care Center meal service(s) any identified menu substitution concerns will be immediately addressed. The Executive Director and/or Designee will conduct an in-service with food service staff related to Food Substitution policy/procedure. 3. As a measure of ongoing compliance, the Executive Director and/or Designee will complete meal service(s) audits in the Health Care Center, said audit will be three times weekly for 30 days, then weekly for 30 days, then monthly x 1, then ongoing as needed. 4. For quality assurance, the Executive Director and/or Designee will review any findings, and subsequent corrective action at least quarterly in the campus quality assurance meeting. The plan will be revised as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased	02/18/2019

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	indicated sugar cream pie. An observation of the lunch meal was made on 1/24/19 at 12:30 p.m. There was no sugar cream pie served. A cookie was served instead. An interview was conducted with Resident 17 on 1/24/19 at 12:26 p.m. in the Main Dining Room, during lunch service. He indicated the menu was wrong everyday. He liked sugar cream pie, and didn't want a cookie. During this interview, Resident 17 was served a cookie on a plate. Resident 17 picked up the plate and handed it to his tablemate. An interview was conducted with Resident 56 on 1/24/19 at 1:12 p.m. She indicated she would have liked to have sugar cream pie, but did not receive it for lunch that day. She received a cookie instead. An interview was conducted with Resident 3 on 1/24/19 at 1:09 p.m. She indicated she did not get sugar cream pie for lunch. An interview was conducted with Resident 36 on 1/24/19 at 1:06 p.m. She indicated lunch was good, but she did not receive the sugar cream pie. An interview was conducted with the DM (Dietary Manager) on 1/24/19 at 1:15 p.m. He indicated a cookie was being served for dessert, instead of sugar cream pie, because he "probably" didn't order it. The 1/22/19 lunch menu was provided by the Executive Director on 1/22/19 at 11:00 a.m. It indicated beef stroganoff, mixed vegetables, dinner roll, and a cookie.		concerns noted and will decrease the frequency of audits f no concerns are noted.	

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	An observation of the lunch meal was made on 1/22/19 at 12:30 p.m. Broccoli was being served instead of the mixed vegetables indicated on the menu. An interview was conducted with Resident 19 on 1/23/19 at 11:04 a.m. She indicated the facility never served what was on the menu, and they were always running out of stuff. She indicated the previous day, the menu indicated mixed vegetables, which she declined, because she didn't care for mixed vegetables. Then, when she went to eat, it was broccoli, not mixed vegetables. She stated, "I like broccoli and would have said yes to that." Resident 19 waved her hand in the air and stated, "I didn't ask for any. It happens all the time." The 1/23/19 lunch menu indicated beef pepper steak, roasted zucchini, pasta salad, dinner roll, and a brownie. An observation of the 1/23/19 lunch meal was made on 1/23/19 at 1:00 p.m. There was no brownie served. A cookie was served instead. 3.1-20(i)(4)			
F 0812 SS=F 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			

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	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, interview, and record review, the facility failed to ensure food was stored properly in the dry storage area and refrigerator, appropriate food temperatures were maintained at the steam table, and trash bins were kept covered when not in continuous use. This had the potential to affect 53 of 53 residents in the facility. Findings include: An initial tour of the kitchen was conducted on 1/22/19 at 11:25 a.m. with the DM (Dietary Manager.) A gray trash receptacle with an inverted lid and a round hole in the center was located near the dishwasher area. There was a wet, brown, food debris stuck to the inverted lid with empty sugar packets stuck to the debris. Food wrappers and raw lettuce inside the trash can were easily observed through the hole in the lid. The trash bin was not in use at this time. The DM indicated the facility had covers for the trash bins, and they should be used. He stated, "I hate seeing the food on there."	F 0812	1. No residents were identified. Dry storage and refrigerator items were immediately stored in the proper area and covered if needed, trash bins were covered when not in continuous use, and food temps taken. 2. All residents in the Health Care Center have the potential to be effected by the alleged deficient practice. The Executive Director and/or Designee will complete an audit of the Health Care Center dry storage, refrigerator, trash bins, and food temps any identified concerns will be immediately addressed. The Executive Director and/or Designee will conduct an in-service with food service staff related to policy/procedure on, Food storage, waste receptacles, and food temps. 3. As a measure of ongoing compliance, the Executive Director and/or Designee will	02/18/2019

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	Another gray trash receptacle was observed just outside of the dry storage room, heaping with trash. The trash bin was not in use. An empty pretzel bag, heavy whipping cream carton, muffin wrapper, ketchup bottle, and used plastic fork were all resting on top of the heap. The dry storage room contained a large bottle of worcestershire sauce on a shelf. The bottle had brown splatter down the front and sides of the bottle. The DM picked up the bottle and threw it into the trash receptacle just outside of the dry storage area. The muffin wrapper fell onto floor, when the bottle was thrown on top of the heap. The front preparation refrigerator contained a small plate with 3 tomato slices on it, exposed to air. The plate was not covered. The DM indicated the tomatoes should not be stored in that manner. A large metal multi-rack system with wheels was observed near the kitchen office. A pan of chocolate chip cookies, uncovered, was on one of the racks. The DM indicated the multi-rack system was used for cooling. He indicated the cookies were cooling, and they did not keep food covered while it was cooling. A second observation of the kitchen was made on 1/24/19 at 12:15. An observation of the DM's office in the kitchen was made. He retrieved one full bag and one partial bag inside of a sealed bag of brown sugar from a crate on his desk. The crate contained other nonfood items. The DM indicated they went through brown sugar so fast, he kept it in his office.		complete audits of dry storage, refrigerator, trash bins, and food temps in the Health Care Center , said audit will be three times weekly for 30 days, then weekly for 30 days, then monthly x 1, then ongoing as needed. 4. For quality assurance, the Executive Director and/or Designee will review any findings, and subsequent corrective action at least quarterly in the campus quality assurance meeting. The plan will be revised as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits f no concerns are noted.	

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	Food temperatures were retrieved from the Main Dining Room steam table by FSA (Food Services Assistant) 3. She used a thermometer to take temperatures of ham, corn bread, spinach, and cottage cheese. The temperature of the cottage cheese was 43.5 degrees Fahrenheit. Food temperatures were retrieved from the steam table in the kitchen by FSA 4. The temperature of the mechanical soft ham was 110 degrees Fahrenheit. An interview was conducted with the Dietary Consultant on 1/28/19 at 4:04 p.m. He indicated the brown sugar should be kept with the rest of the dry food. The Dietary Department Storage policy was provided by the DHS (Director of Health Services) on 1/25/19 at 8:53 a.m. It read, "Food and supplies shall be properly stored to keep foods safe and preserve flavor, nutritive value and appearance....Prepared perishables such as salads, puddings, milk, etc are stored in a refrigerator and covered, labeled and dated until used." The Garbage and Refuse policy was provided by the DHS on 1/25/19 at 8:53 a.m. It read, Garbage receptacles will be lined with sturdy garbage bags and covered at all times, except during active use, and when being transported to the dumpster area." 3.1-21(i)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program			

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	designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and			

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	(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation and interview the facility failed to maintain infection control during medication administration for 1 of 6 resident's observed during medication administration. (Resident 27) Findings include: The clinical record for Resident 27 was reviewed on 1/24/2019 at 2:30 p.m. The diagnosis for Resident 27 included, but were not limited to, constipation.	F 0880	1. 1. Resident # 27 had no adverse effects. RN #9 had education provided on maintaining infection control during medication administration. 2. 2. All residents on the Health Care Center that have medication administered have the potential to be affected by alleged deficient practice. The Director of Health Services and/or Designee will conduct an in-service with nurses on Infection Control related	02/18/2019

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	A physicians order dated 9/13/2018 indicated Resident 27 was to receive Miralax (laxative) 17 grams mixed in 8 ounces of water daily for constipation. On 1/24/2019 at 9:35 a.m., Registered Nurse 9 was observed preparing medications for Resident 27. She was unable to locate the Miralax in the medication cart. She locked the medication cart with her right hand. She then went to the medication room and opened the medication room door, touching the door with her hands. She then left the medication room and walked to the treatment cart. She reached into a pocket with her right hand and removed her keys. She used the keys to open the treatment cart, and then opened a draw on the treatment cart using her right and left hands to locate the Miralax. She then shut and locked the medication cart using her right hand. She returned to the medication cart and removed a permanent marker from her pocket with her right hand. She wrote the date on the bottle of Miralax. She then removed the cap from the bottle and used her right thumb to puncture the seal on the top of the Miralax bottle. She did not perform hand hygiene prior to using her thumb to open the seal. During an interview on 1/25/2019 at 2:20 p.m., the Director of Health Services indicated that infection control had not been maintained when opening the seal of the Miralax bottle was opened. 31-18(l)		to medication administration. 3. 3. As a measure of ongoing compliance, The Director of Health Services and/or Designee will audit nurse(s) during medication administrations, said audit will include up to three nurses, three times weekly for 30 days, then once weekly for 30 days, then monthly x1, then ongoing as needed. 4. 4. For quality assurance, The Director of Health Services and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quality assurance meeting. The plan will be revised as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure	R 0000	**Preparation or execution of**	

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	Survey. This visit included a Recertification, State Licensure Survey. Survey Dates: January 22, 23, 24, 25, 28, and 29, 2019. Facility Number: 004268 Residential Census: 29 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 4, 2019		**this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during Recertification and Complaint visit with exit on January 29, 2019. Please accept this plan of correction as the provider's credible allegation of compliance as of February 18, 2019. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.**	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least			

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	annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview and record review, the facility failed to ensure a staff person had a 2nd step tuberculin skin test timely for 1 of 10 employee files reviewed. (Certified Resident Care Associate CRCA 18) Findings include: The employee file for CRCA 18 indicated she had a start date of 11/16/18 as a part time employee. The 1st tuberculin skin test was given on 10/18/18 and read on 10/21/18. The 2nd tuberculin skin test	R 0121	1. Staff # 18 will have a 2step PPD initiated. 2. All new hired staff on the AL have the potential to be effected.The Director of Health Services and/or Designee will conduct an audit on new staff hired as of 1/23/2019, to ensure compliance, any staff identified as non-compliant will have 2nd step PPD initiated. The Director of Health Services and/or Designee	02/18/2019

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	was given on 11/25/18 and read on 11/27/18. An interview was conducted with Nurse Consultant 1 on 1/29/19 at 9:15 a.m. She indicated the 2nd step tuberculin skin test for CRCA 18 was missed. It should have been done 21 days after the 1st step. A tuberculin skin test policy was provided by the Director of Nursing Services on 1/29/19 at 12:00 p.m. It indicated "..Purpose: To create a TB (tuberculosis) Results Summary for each staff member upon hire. Procedures 1. Upon hire each employee shall receive a Two Step Mantoux test shall be recorded in the TB Results Summary and placed in the personnel file..."		will complete an in-service with staff on employee records in regards to PPDs. 3. As a measure of ongoing compliance, The Director of Health Services and/or Designee will complete an audit on all new hired AL staff, said audit will be three times weekly for 30 days, then weekly for 30 days, then monthly x 1, then ongoing as needed. 4. For quality assurance, Director of Health Services and/or Designee will review any findings, and subsequent corrective actions. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted.	
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: (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.			

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	Based on interview and record review, the facility failed to obtain a weight, upon admission, for 1 of 5 residents whose clinical records were reviewed. (Resident 10) Findings include: The clinical record for Resident 10 was reviewed on 1/28/19 at 2:30 p.m. The diagnoses for Resident 10 included, but were not limited to, Parkinson's disease and dementia. She was admitted to the facility on 1/4/19. There were no weights included in the service plan or vitals section of the electronic health record for Resident 10. An interview was conducted with Consultant 1 on 1/28/19 at 3:42 p.m. She indicated she was unable to find an admission weight for Resident 10 and would have it done in the morning. The Weights Guidelines was provided by Consultant 1 on 1/29/19 at 9:15 a.m. It read, "Purpose: To ensure residents are maintaining good nutrition to remain close to ideal body weight....Weights shall be recorded in the electronic health record. a. Weight shall also be recorded on the Evaluation and Service Plan form at admission and quarterly."	R 0216	1. Resident # 10 had weight obtained. 2. All new admissions on the AL have the potential to be effected.The Director of Health Services and/or Designee will conduct an audit on new residents admitted as of 1/23/2019, to ensure admit weight is obtained, anyone identified with no admit weight will have weight immediately obtained. The Director of Health Services and/or Designee will complete an in-service with AL nurses on obtaining admission weights. 3. As a measure of ongoing compliance, The Director of Health Services and/or Designee will complete an audit on all new AL residents, said audit will be three times weekly for 30 days, then weekly for 30 days, then monthly x 1, then ongoing as needed. 4. For quality assurance, Director of Health Services and/or Designee will review any findings, and subsequent corrective actions. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted.	02/18/2019
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			

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	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 food was stored properly in the dry storage area and refrigerator, appropriate food temperatures were maintained at the steam table, trash bins were kept covered when not in continuous use, and appropriate hand hygiene was performed during meal service. This had the potential to affect 29 of 29 residents in the facility. Findings include: An initial tour of the kitchen was conducted on 1/22/19 at 11:25 a.m. with the DM (Dietary Manager.) A gray trash receptacle with an inverted lid and a round hole in the center was located near the dishwasher area. There was a wet, brown, food debris stuck to the inverted lid with empty sugar packets stuck to the debris. Food wrappers and raw lettuce inside the trash can were easily observed through the hole in the lid. The trash bin was not in use at this time. The DM indicated the facility had covers for the trash bins, and they should be used. He stated, "I hate seeing the food on there." Another gray trash receptacle was observed just outside of the dry storage room, heaping with trash. The trash bin was not in use. An empty pretzel bag, heavy whipping cream carton, muffin wrapper, ketchup bottle, and used plastic fork were all resting on top of the heap. The dry storage room contained a large bottle of	R 0273	1. No residents identified. 2. All residents in the AL have the potential to be effected. The Executive Director and/or Designee will complete an audit of the AL dry storage, refrigerator, trash bins, and food temps any identified concerns will be immediately addressed. The Executive Director and/or Designee will conduct an in-service with food service staff related to policy/procedure on, Food storage, waste receptacles, hand washing, and food temps. 3. As a measure of ongoing compliance, the Executive Director and/or Designee will complete audits of dry storage, refrigerator, trash bins, hand washing, and food temps on the AL, and said audit will be three times weekly for 30 days, then weekly for 30 days, then monthly x 1, then ongoing as needed. 4. For quality assurance, the Executive Director and/or Designee will review any findings, and subsequent corrective action at least quarterly in the campus quality assurance meeting. The plan will be revised as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits f no	02/18/2019

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	worcestershire sauce on a shelf. The bottle had brown splatter down the front and sides of the bottle. The DM picked up the bottle and threw it into the trash receptacle just outside of the dry storage area. The muffin wrapper fell onto floor, when the bottle was thrown on top of the heap. The front preparation refrigerator contained a small plate with 3 tomato slices on it, exposed to air. The plate was not covered. The DM indicated the tomatoes should not be stored in that manner. A large metal multi-rack system with wheels was observed near the kitchen office. A pan of chocolate chip cookies, uncovered, was on one of the racks. The DM indicated the multi-rack system was used for cooling. He indicated the cookies were cooling, and they did not keep food covered while it was cooling. A second observation of the kitchen was made on 1/24/19 at 12:15. An observation of the DM's office in the kitchen was made. He retrieved one full bag and one partial bag inside of a sealed bag of brown sugar from a crate on his desk. The crate contained other nonfood items. The DM indicated they went through brown sugar so fast, he kept it in his office. An interview was conducted with the Dietary Consultant on 1/28/19 at 4:04 p.m. He indicated the brown sugar should be kept with the rest of the dry food. Food temperatures were retrieved from the steam table in the dining room by Cook #7 on 1/28/19 at 12:02 p.m. The temperature of the potatoes was retrieved at 126.7 degrees Fahrenheit. Cook #7 did not remove the potatoes from the steam table and		concerns are noted.	

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	FSA (Food Services Assistant) 2 continued to serve the potatoes. An observation of the lunch meal service in the dining room was made on 1/28/19 at 12:05 p.m. FSA 2 was serving food from the steam table. She had a glove on her right hand and no glove on her left hand. She left the steam table to serve a plate of food to a resident sitting at a table in the back of the dining room. She picked up a card from the table and placed it in her pocket, then touched a chair. On her way back to the steam table, FSA 2 stopped at another table, picked up a glass, filled the glass with soda from the fountain, gave the glass to a resident, then went back to the steam table. FSA 2 left the steam table, went into the kitchen, received a plate with chicken tenders from a kitchen staff member, then came back to the steam table, put some potatoes on the plate with the chicken tenders, then served the plate to Resident 4. FSA 2 came back to the steam table, scooped some potatoes and sour kraut and sausage onto 2 plates with her gloved right hand. Then FSA 2 used the same right hand to place 2 rolls onto each plate. FSA 2 then served one plate to Resident 18 and the other to another resident. FSA 2 then rubbed the side of her face with her gloved right hand, did not wash her hands or remove her glove, went into the kitchen, came out, touched the kitchen door with her gloved hand, then proceeded to serve food from the steam table. She prepared another plate, grabbed a roll with right gloved hand, placed it onto a plate, and served the plate to Resident 6. FSA 2 never removed her glove or used hand hygiene during the entire observation. An interview was conducted with the ADHS (Assistant Director of Health Services) on 1/28/19 at 12:50 p.m. After being informed of the above			

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	observation, she indicated FSA 2 should not be touching food, serving food, or preparing plates without washing her hands. The Dietary Department Storage policy was provided by the DHS (Director of Health Services) on 1/25/19 at 8:53 a.m. It read, "Food and supplies shall be properly stored to keep foods safe and preserve flavor, nutritive value and appearance....Prepared perishables such as salads, puddings, milk, etc are stored in a refrigerator and covered, labeled and dated until used." The Garbage and Refuse policy was provided by the DHS on 1/25/19 at 8:53 a.m. It read, Garbage receptacles will be lined with sturdy garbage bags and covered at all times, except during active use, and when being transported to the dumpster area." The Retail Food Establishment Sanitation Requirement, dated 11/13/04, indicated, "410 IAC 7-24-129 When to wash hands Sec. 129. (a) Food employees shall clean their hands and exposed portions of their arms as specified under section 128 of this rule immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and the following: ...(6) After handling soiled surfaces, equipment, or utensils. (7) During food preparation, as often as necessary to remove soil and contamination and to prevent cross-contamination when changing tasks. (8) When switching between working with raw food and working with ready-to-eat food.(9) Before touching food or food-contact surfaces. (10) Before placing gloves on hands.(11) After engaging in other activities that contaminate the hands. (b) For purposes of this section, a			

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	violation of subsection (a) is a critical item....410 IAC 7-24-177 Food storage Sec. 177. (a) Except as specified in subsections (b) and (c), food shall be protected from contamination by storing the food as follows: (1) In a clean, dry location. (2) Where it is not exposed to splash, dust, or other contamination. (3) At least six (6) inches above the floor. (4) In a manner to prevent overcrowding. (5) In packages, covered containers, or wrappings. (b) Food in packages and working containers may be stored less than six (6) inches above the floor on case lot handling equipment. (c) Pressurized beverage containers, cased food in waterproof containers, such as bottles or cans, and milk containers in plastic crates may be stored on a floor that is clean and not exposed to floor moisture. (d) For purposes of this section, a violation of subsection (a)(1), (a)(2), (a)(3), (a)(4), (b), or (c) is a noncritical item. (e) For purposes of this section, a violation of subsection (a)(5) is a critical or noncritical item based on the determination of whether or not the violation significantly contributes to food contamination, an illness, or an environmental health hazard....410 IAC 7-24-187 Potentially hazardous food; hot and cold holding Sec. 187. (a) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under section 193 of this rule, potentially hazardous food shall be maintained as follows: (1) At one hundred thirty-five (135) degrees Fahrenheit or above, except that roasts cooked to a temperature and for a time specified under section 182(b) of this rule or reheated as specified in section 188(e) of this rule may be held at a temperature of one hundred thirty (130) degrees Fahrenheit.7-24-392 Covering receptacles Sec. 392. (a) Receptacles and waste handling units for refuse, recyclables, and returnables shall be kept covered: (1) inside the retail food establishment if			

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	the receptacles and units: (A) contain food residue and are not in continuous use; or (B) after they are filled; and (2) with tight-fitting lids or doors if kept outside the retail food establishment. (b) For purposes of this section, a violation of subsection (a) is a noncritical item.			