STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING			
NAME OF PROVIDER OR SUPPLIER PRIMROSE RETIREMENT COMMUNITY OF ANDERSON			1118 V	ADDRESS, CITY, STATE, ZIP COD V CROSS ST RSON, IN 46011	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R 0000					
Bldg. 00	IN00432559, IN00 IN00429616. Complaint IN0043 to the allegations a Complaint IN0043 to the allegations a Complaint IN0043 to the allegations a Complaint IN0042 to the allegations a Survey date: 5/3/2 Facility number: 0 Residential Census	2225 - State deficiencies related re cited at R0273. 0109 - State deficiencies related re cited at R0273. 9616 - State deficiencies related re cited at R0273. 4 11806 :: 30 ential Findings are cited in	R 0000		
		npleted May 9, 2024.			
R 0273 Bldg. 00	(f) All food prepai (excluding areas maintained in acc local sanitation a standards, includ	nal Services - Deficiency ration and serving areas in residents ' units) are cordance with state and and safe food handling ing 410 IAC 7-24.	D 0272	Diagon account this are the Di	05/15/2021
	review, the facility	on, interview, and record failed to store, prepare, and ler safe sanitary conditions.	R 0273	Please accept this as the Plar Correction for Primrose Retire Community of Anderson. We	ement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUR				TITLE	(X6) DATE

(X6) DATE

LaShelle Crawley **Executive Director** 05/24/2024

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

State Form Event ID: 85CO11 Facility ID: 011806 If continuation sheet Page 1 of 7

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
			B. WI	NG		05/03/	2024	
			_	STREET /	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER					CROSS ST			
PRIMROSE RETIREMENT COMMUNITY OF ANDERSON					SON, IN 46011			
TRIMITOGE RETIREMENT COMMONT OF TRIBERCON				ANDLIN				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE	
	•	ice had the potential to impact			request a paper review.			
	30 of 30 residents	who resided in the facility.						
	F' 1' ' 1 1				R273 Food and Nutritional			
	Findings include:				Services			
	D : 12.1 .	5/2/24 40.50			•What corrective action(s) will			
	-	ur on 5/3/24 at 9:50 a.m. to			accomplished for those reside			
	10:10 a.m., the foll	lowing concerns were observed:			found to have been affected b	y tne		
	Dagah in "Dafniaan	stan III contained the following			deficient practice.	4		
		ator 1" contained the following			No residents were affect			
	undated and unlabeled items: three bowls of green beans, one bowl of baked beans,				by the alleged deficient praction All food preparation and			
					serving areas (excluding area			
					residents' units) are maintaine			
	one-half of a jug of				accordance with state and loc			
		red velvet cake, cut into slices,			sanitation and safe food hand			
	-	ure bleeding through the			standards.	g		
	-	nk discoloration of the			This facility stores,			
	frosting,				prepares and distributes food			
	one bowl of beets,				under safe sanitary conditions	i.		
	two bowls of cottag	ge cheese,			•How the facility will identify of			
	one pitcher of crant	perry juice,			residents having the potential			
	one pitcher of iced	tea,			be affected by the same defici	ent		
	multiple trays of sa	auce cups- with and without			practice and what corrective a	ction		
	lids- containing hor	ney mustard and Italian			will be taken.			
	dressing,				All residents have the			
	one bowl of tapioca	-			potential to be affected by the			
	multiple trays of ge	elatins and puddings.			alleged deficient practice.			
					Immediate action was			
	During an interview				taken to remove all undated a	nd		
	· ·	y Employee 2 indicated food			unlabeled items from the			
		dated and labeled. The			refrigerator.			
		now how long food could be			All food is dated and			
	_	ntor. The Dietary Manager			labeled according to policy an	a		
	-	loyees when to pull out food There was no posting in the			procedure.	4464		
	•	m guidance regarding how			The Dietary manager at			
		held in the refrigerator.			labeling and dating to the shift check list.	•		
	Tong rood could be	neid in the terrigerator.			Guidance was posted ir			
	During an interviev	v at the time of the			the kitchen regarding how long			
	-	y Employees 2 and 3 both			food could be held in the	9		
	55501 vacion, Dictar	j Employees 2 and 3 oom						

State Form Event ID: 85CO11 Facility ID: 011806 If continuation sheet Page 2 of 7

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		B. WING 05/03/2024			/2024		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
DDIMBOOF DETIDEMENT COMMUNITY OF ANDERSON					CROSS ST		
PRIMROSE RETIREMENT COMMUNITY OF ANDERSON				ANDER	RSON, IN 46011		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CO		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	indicated they did 1	not know when the unlabeled			refrigerator.		
	and undated food h	ad been prepared.			The Executive Director	had	
					an in-service meeting with sta	ff on	
	Reach in "Refrigera	ator 2" contained the following			5/6/2024 addressing the		
	undated and unlabe	eled foods:			importance of storing, preparir	ng,	
					dating, and labeling items place	ed	
	One bag of cubed h	nam,			in the refrigerators.		
	one container of sh	redded cheese,					
	one container of gr	een olives,			The drip pans under the	:	
	one container of bla	ack olives,			burners on the stove and the I	ip of	
	one container of ch	erry tomatoes,			the overhead exhaust hood ar	е	
	one container of dr	ied cranberries, and			examined for residue and clea	ned	
	one large container	of thick, green liquid that			accordingly.		
	could not be identif	fied by the staff.			The Dietary manager		
					added cleaning of the drip par	ıs	
	Reach in "Refrigera	ator 2" contained the following			under the burners on the stove	e and	
	dated, labeled food	s, which were older than 7			the lip of the overhead exhaus	t	
	days:				hood to the shift check list.		
					The Dietary manager o	r	
	One container of le	entil soup, dated 4/17/24 (16			designee will sign off on the cl	neck	
	days old),				list after each shift to confirm l	ists	
		inestrone soup, dated 4/19/24			are completed.		
	(14 days old),				Temperature and sanitize		
	_	ef, dated 4/20/24 (13 days old),			levels are checked and record	ed	
	and				daily according to regulation.		
	_	urkey, dated 4/25/24 (7 days			The Dietary Manager or		
	old).				designee will review all dishwa		
					temperature and sanitizer leve		
		er had a bag of french fries,			dish machine temperature log		
	which was torn open, and exposing the contents, two of the three drip pans located under the				quat sanitizer PPM log daily fo	or 2	
					weeks and weekly ongoing to		
		e had a heavy dark brown			ensure temperatures are withi	n the	
	residue, and	1 1 11 11 1			appropriate range.		
	_	ead exhaust hood had a heavy,			Food temperatures are		1
	liquid, dark grease	build-up on it.			taken prior to serving food utili	zıng	
	m 1' 1 ' 1 ' 1	1			the cooking and reheating		
		d signs posted in the area			temperature log.		
	_	low-temperature machine.			The Dietary Manager or	•	1
		s 2 and 3 indicated they did not			designee will review all food		
know what temperature the wash or rinse water		1		temperature cooking and rehe	ating	1	

State Form Event ID: 85CO11 Facility ID: 011806 If continuation sheet Page 3 of 7

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING 00		COMPLETED			
		B. WING			05/03/2024			
				_	_		-	
NAME OF I	PROVIDER OR SUPPLIEI	3			ADDRESS, CITY, STATE, ZIP COD			
				1118 W CROSS ST				
PRIMROSE RETIREMENT COMMUNITY OF ANDERSON				ANDER	RSON, IN 46011			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DROVIDEDIC DI AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	1.	DATE	
	should reach. Both	Dietary Employees 2 and 3			temperature log daily for 2 we	eks		
	indicated they did i	not know how to test the			and weekly ongoing to ensure			
	sanitizer concentrat	tion in the rinse water cycle.			temperatures are taken prior to	0		
	Both indicated the	dietary manager generally did			food service.			
	this task and she wa	as off duty today. Both			Food is handled safely,	and		
	Dietary Employees	indicated they did not know			dietary staff wash their hands	per		
	where the log for re	ecording dishwasher			state recommendation.			
	temperatures and sa	anitation level was kept. Three			The Dietary Manager or			
	dishwasher full cyc	les were run. The			designee will observe meal			
	temperatures of the	first run was 91 degrees (F)			services for safe food handling	g and		
	Fahrenheit for the v	was and 91 degrees F for the			proper handwashing using hai	nd		
	rinse. Dietary Employee 2 indicated the booster				sanitation log.			
	needed turned on to	heat the rinse water fully.			Dietary staff will be			
	Dietary Employee	2 turned on the booster. The			evaluated for proper handwas	hing		
	second dish washer	cycle was 99 degrees F for			techniques using the hand			
	the wash and 120 d	egrees F for the rinse. The			sanitation log weekly times fou	ır		
	third run cycle was	103 degrees F for the wash			and monthly ongoing.			
	and 135 degrees F	for the rinse. Dietary			Dietary staff were re-educated	on		
	Employees 2 and 3	both indicated they did not			the following policies and			
	know if these were	acceptable ranges. Dietary			procedures: Date Marking, Sa	afe		
		ed some dishes had already			Food Handling, Hand Washing] ,		
	been washed using	the same dishwasher earlier in			and Commercial Kitchen			
	the shift.				Equipment Maintenance and l	Jse		
					on 5/15/2024. Dietary staff w	ere		
	_	neal service on 5/3/24 from			also re-educated on the prope	r		
	•	2 p.m., the following concerns			temperature and monitoring of	the		
	were observed:				temperatures for the dishwash	er		
					and how to test the sanitizer			
		2 indicated she had not taken			concentration in the rinse water	er		
	_	res prior to beginning to serve			cycle on 5/15/2024.			
	food. She did not know she was supposed to				•What measures will be put int			
	_	re service. She did not know of			place or what systemic change			
	any log for recording	ng food temperatures.			the facility will make to ensure			
					that the deficient practice does	s not		
		2 placed a grill cheese sandwich			recur.			
	_	e sandwich, and removed it			Dietary manager or			
		tary Employee 2 touched the			designee will review all dietary			
		wich with her gloves, resulting			refrigerators daily and docume	ent		
	_	oves. With the same			using refrigerator/freezer			
contaminated gloved hands, she touched frozen		1		temperature logs for 2 weeks	and			

State Form Event ID: 85CO11 Facility ID: 011806 If continuation sheet Page 4 of 7

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUM		IDENTIFICATION NUMBER	A. BUILDING 00		COMPLETED		
		B. W	B. WING			05/03/2024	
				_			
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					CROSS ST		
PRIMROSE RETIREMENT COMMUNITY OF ANDERSON				ANDER	RSON, IN 46011		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE			COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
	fish and shrimp. Sl	he walked to the freezer and			weekly ongoing to ensure that		
	touched the freezer	handles with the same gloves.			items placed in the refrigerato		
		ved hands, she removed the			are labeled and dated.		
		ries from the freezer. Using the			Dietary manager or		
	_	egan portioning food on to			designee will review the stove	and	
	_	th the same contaminated			the overhead exhaust hood da		
		I the food contact surface of			using the daily cleaning log for	-	
		hed seven (7) plates in this			weeks and weekly ongoing to		
	•	the same gloved hands, she			ensure that the stove and the		
		h and shrimp in the deep fryer.			overhead exhaust hood are fre	ee	
	1	1 1 3			from residue.		
	At 12:21 p.m., she removed her gloves and went to				Dietary manager or		
	the hand washing sink. She washed her hands for				designee will review the		
	_	ls and turned off the faucet			dishwasher temperature logs	dailv	
		hands. She then dried her			using the dishwasher machine	-	
	_	towel. After washing her			temperature log for 2 weeks a		
		gloves. She then began the			weekly ongoing to ensure that		
		ad displayed earlier touching,			dishwasher temperatures and		
	_	refrigerator and freezer			sanitizer levels are in the		
	_	ame pair of gloves. She			appropriate range.		
		ontact with the food after her			Dietary Manager or		
		ntaminated. She touched the			designee will review all food		
	-	n of the plate while serving			temperature cooking and rehe	ating	
		s continued until 12:26 p.m.,			temperature log daily for 2 we	~	
	^	her gloves and completed a			and weekly ongoing to ensure		
		hand washing and turned off			temperatures are taken prior t		
	the sink with her w	_			food service.		
					The Dietary Manager or	.	
	After washing her l	nand at 12:26 p.m., she returned			designee will observe meal		
		of food preparation and			services for safe food handling	and I	
		gain. She touched food, plate			proper handwashing using the		
	`	nandles, and cooking			hand sanitation log.		
		the same pair of contaminated			Dietary staff will be		
	gloves.	•			evaluated for proper handwas	hina	
					techniques using the hand	5	
	During an observat	ion of the dishwasher area,			sanitation log weekly times for	_{ır}	
	_	e Administrator on 5/3/24 at			and monthly ongoing		
		ministrator pointed out a sign			The expectation is 95%		
					-		
					1 · · · · · · · · · · · · · · · · · · ·	_{ted}	
	posted on the wall of the dishwashing area which indicated wash and rinse water temperature must				completion of all forms. Completion rates will be repor	ted	

State Form Event ID: 85CO11 Facility ID: 011806 If continuation sheet Page 5 of 7

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DAT			(X3) DATE	DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED		
			B. WING			05/03/	05/03/2024	
				CTD FFT A	ADDRESS CITY STATE ZID COD			
NAME OF I	ROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD			
					CROSS ST			
PRIMRO	SE RETIREMENT	COMMUNITY OF ANDERSON		ANDER	SON, IN 46011			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG CROSS-REFERENCED TO THE APPROPRIAT			DATE	
	be a minimum of 12	20 degrees. She indicated the			monthly to the Quality Assurar	nce		
	dishwasher tempera	ature log had not been			committee.			
	completed for the n	nonth of May 2024 (three			How the corrective			
	days).				action(s) will be monitored to			
					ensure the deficient practice w	/ill		
	A current, 6/4/20, f	acility policy titled "Commercial			not recur, i.e., what quality			
	Kitchen Equipment	Maintenance and Use,"			assurance program will be put	into		
	provided by the Ad	ministrator on 5/3/24 at 1:26			place; and			
	p.m., indicated the	following:			Dietary manager or			
	"Exhaust Hood: a	a.) Remove and clean filters			designee will check the followi	ng		
	monthly. They may	y need to be cleaned more			logs daily for the next 2 weeks	;		
	often due to the typ	e of food cooked b.) Empty			and weekly ongoing to ensure			
	drip pans. c.) Wipe down the hood to remove				alleged deficiencies do not oc	cur:		
	excessive grease bu	ildup"			Dish machine temperature lo	og		
					Quat Sanitizer PPM log			
	A current, 1/1/15, f	acility policy titled "Hand			Cooking & Reheating			
	Washing," provided	l by the Administrator on			temperature log			
	5/3/24 at 1:26 p.m.,	indicated the following:			Refrigerator/Freezer temper	ature		
	"1. Avoid touchi	_			log			
		ogether all surfaces of the			Daily cleaning log			
		at least 20 seconds			Hand sanitation log			
	10. Use a dry paper	towel to turn water off"			The expectation is 95%			
					completion of all forms.			
		facility policy titled "Safe			Completion rates will be report			
		ovided by the Administrator			monthly to the Quality Assurar	nce		
	•	m., indicated the following:			committee.			
	"Food must be se				The Quality Assurance			
	-	neasure food temperatures, a			committee will review the findi	ngs		
	-	may be used. Food			monthly and take appropriate			
	-	d be recorded prior to meal			actions if needed.			
	service"							
		0.11.			By what date the systemic			
		facility policy titled "Date			changes will be completed			
		by the Administrator on			5/15/2024			
	-	indicated the following:						
		ge refrigerated, ready to eat,						
		us foods within 7 days.						
	•	arate label the date prepared,						
		date thawed of any ready to						
	eat"		1					

State Form Event ID: 85CO11 Facility ID: 011806 If continuation sheet Page 6 of 7

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

PRINTED: 05/24/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/03/2024	
NAME OF PROVIDER OR SUPPLIER PRIMROSE RETIREMENT COMMUNITY OF ANDERSON				1118 W	ADDRESS, CITY, STATE, ZIP COD CROSS ST SON, IN 46011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		to complaints IN00432559, 430109, and IN00429616.					

State Form Event ID: 85CO11 Facility ID: 011806 If continuation sheet Page 7 of 7