STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155473	A. BUILDING 00 B. WING	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF BERNE	1065 PARKWAY ST BERNE, IN 46711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: September 30, October 1, and 2, 2024. Facility number: 000546 Provider number: 155473 AIM number: 100267370 Census Bed Type: SNF/NF: 39 Total: 39 Census Payor Type: Medicare: 6 Medicaid: 26 Other: 7 Total: 39 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed Ocotber 3, 2024	F 0000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law: or agreement of provider of the truth of the facts or alleged 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 to respond to the allegation of noncompliance during an annual recertification survey dated October 2, 2024 Please accept this plan of correction as the facility's credible allegation of compliance. Given the facility's survey history of minimal cited deficiencies over the past year, and one alleged deficiency during this annual recertification survey, the provider/facility respectfully requests a desk review with paper compliance be considered in establishing the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brenda Johns	Executive Director	10/18/2024

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.

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F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review the facility failed to maintain sanitary conditions in the kitchen. 38 of 39 residents who riside in the facility eat food prepared in the kitchen. Findings include: During an observation on 09/30/24 at 09:22 AM, Cook 2 pulled the grease traps under the first set of burners. There were 2 layers of foil present. On the top layer of foil was burnt noodles, carrots, and other unidentifiable debris as well as other odd, shaped discolorations on top of each other. The oven under the first set of burners did not close fully. The walk in cooler had debris of various sizes and substance; cardboard, plastic, and paper were identified under the racks. There was a pipe coming from the top of the walk in freezer wrapped in black tape, at an elbow of the pipe was a square plastic container with green markings of 1 cup, 2 cups, 3 cups, and 4 cups underneath. There was liquid inside the container. The liquid was clear and frozen. There was a frozen substance coming out the left side of the container. The walk in freezer did not have a thermometer present on the inside. Within the kitchen there were 3 red buckets of sanitation solution. Dietary Aide 3 assisted in testing a bucket for correct strength. When Dietary Aide 3 removed strip he immediately indicated the strip was very light. The strip indicated a strength of 25 per Dietary Aide 3. He indicated the solution was weak as noted by the light color on the strip. During an interview on 09/30/24 at 09:22 AM,	F 0812	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law: or agreement of provider of the truth of the facts or alleged 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 to respond to the allegation of noncompliance during an annual recertification survey dated October 2, 2024 Please accept this plan of correction as the facility's credible allegation of compliance. Given the facility's survey history of minimal cited deficiencies over the past year, and one alleged deficiency during this annual recertification survey, the provider/facility respectfully requests a desk review with paper compliance be considered in establishing the provider is in substantial compliance. - What corrective action(s) will be accomplished for those	10/28/2024

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	Cook 2 indicated the Dietary Manager (DM) was not in. Cook 2 indicated the oven was still operable and a work order was placed to fix the door to the oven. Cook 2 was unsure when the work order was placed. Cook 2 indicated to determine the temperature, the staff "just guess". Cook 2 proceeded to show documentation of a recorded temperature for the deep freeze on 9/30/24. Cook 2 indicated there was not a thermometer present when the temperature was recorded as Zero. During an interview on 09/30/24 at 09:52 AM, Dietary Aide 3 was unable to determine where to get the information for a correct concentration. Records were reviewed 10/1/24 at 8:26AM, findings as follows: A work order for the right oven door was created on 8/4/24, then updated on 8/23/24. A comment on the document indicated hinges were worn out and parts needed to be located. The work order indicated the vendor would call when parts are found. In the comments section, a note indicated professional food service had been called on 9/30/24, the service would be sending out mobile service as soon as today to make correction to door on stove. The log for 3-Compartment Sink, dated August 2024, had an area for test strip PPM, wash temp, and rinse temperature. The log was blank for the effective or the expected numbers. The weekly cleaning task list contained: delime dishwasher, wipe down counter and drawers, clean coffee pots, clean hood filters, change aluminum foil in stove, clean stove burners, wipe down plate warmers, wipe down steam table, and		residents found to have been affected by the deficient practice; No residents were noted to be affected. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents consuming meals from the kitchen had the potential to be affected by the alleged deficient practice. Infection control logs reviewed with no food borne illness noted which assisted with determination that no residents were affected. The walk in cooler and freezer floors were swept and mopped immediately The alleged missing thermometer was located within the cooler and freezer. Staff shown location. The freezer condensation drainpipe repaired. 2 ovens are available for food preparation. Oven door hinges replaced by contracted vendor. Facility is in the process of obtaining quotes to replace unit. Aluminum foil removed from stove grease traps. Grease trays	

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	wipe down all stainless steel appliances. At the bottom of the sheet were the directions: All cleaning jobs need to be done by the following Sunday. No monthly or daily cleaning lists were provided. During a continuous observation on 10/01/24 from 10:26 AM to 11:20 AM, A red bucket was tested slightly darker than 100. During the observation, the DM washed her hands 3 times. The first time she washed her hands was for 7 seconds. The second time was for 7 second seconds. The third time was for 7 seconds. The DM indicated the amount of time to wash hands was 20 seconds minimum. During an interview, on 10/01/24 at 11:20 AM, the DM indicated the sanitation buckets were to test between 100 and 200. The DM further indicated the sanitation requirements were at the top of the recording page where staff were expected to record the bucket sanitation. During an interview on, 10/2/24 at 11:06AM, the Maintenance Director indicated the pipe in the walk in freezer was cracked at the top at a joint. They were unsure where it was cracked and when they noticed it leaking, they wrapped it in heat tape and put a container under to catch the leak until it could be properly fixed. A policy titled, "Cleaning and Sanitizing Equipment" dated 1/23 was provided 10/1/24 at 8:26AM by the Administrator. The policy indicated dietary staff will maintain cleaning and sanitizing solution I clean receptacles and at proper concentration ... A policy titled; "Cleaning Schedules" dated 01/12 was provided 10/1/24 at 8:26AM by the		cleaned per policy. Education with post-test knowledge evaluation via quiz to be provided to the facility's dietary staff on the facility policies of -Infection Control: Handwashing, Infection Control: Cleaning and Sanitizing Equipment, Infection Control: Freezer/Cooler Cleaning and Kitchen Operations including freezer/cooler temperature monitoring and recording. Attachment a pages 1-14 Education to be provided to the dietary staff regarding accurate documentation requirements for sanitation and temperature logs. Attachment a pages 1-14 Handwashing appropriate sanitization testing values posted in kitchen near handwashing and three compartment sink for staff reference. Attachment b pages 1-3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Monthly cleaning logs to be reviewed three times/week by the Dietary Manager or designee and submitted to the Executive	

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	Administrator. The dietary staff will maintain the sanitation of the dietary department through compliance with a written, comprehensive cleaning schedule ... 3.1-21(j)(2)(3)		Director or designee twice a week for four weeks, followed by weekly review for twelve weeks, and then transition to monthly review for two months. Walk through kitchen inspection to be conducted by Executive Director or designee twice a week for four weeks, followed by weekly for 12 weeks, and then transition to monthly for 2 months. Attachment c pages 1 Random handwashing audits to be completed by Executive Director or designee twice a week for four weeks, followed by weekly observations for twelve weeks, and then transition to monthly observations for two months. Attachment d pages 1 Weekly inspection of freezer condensation drain to be completed to ensure drain is functioning as designed and in working order. Weekly x 6 months All audits will be reviewed by the QAPI committee, which operates under the supervision of the Executive Director. Additional monitoring will be conducted at the discretion of the QAPI committee until 100% compliance is obtained.	