STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APPLE RIDGE ASSISTED LIVING AND MEMORY CARE	3320 EAST STATE BOULEVARD FORT WAYNE, IN 46805

(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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: March 3 and 4, 2020 Facility number: 012107 Residential Census: 58 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed March 9, 2020.	R 0000	"This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of Woodview Assisted Living as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies."	

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

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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R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on interview, and record review, the facility failed to ensure reference screenings were completed for 1 out of 5 employees reviewed for employee screenings. Findings include: Employee 13's record indicated no reference screenings were completed. A form, Verification and Reference Check Authorization, was located in Employee 13's record but was not completed. During an interview on 3/4/2020 at 3:53 p.m., the ED (Executive Director) indicated Employee 13 had worked for the facility previously and thought those references completed at that time would be okay. The facility provided no policy for screening process of employees.	R 0116	R 116 -Personnel References 1.CORRECT ACTIONS FOR AFFECTEDRESIADENTS: All department heads and the full-time receptionist have been in-serviced that all new hires and re-hires will have reference checks completed prior to returning to work. 2.METHODS FOR IDENTICATION OTHER RESIDENTS POTENTIALLY AFFECTED RESIDENTS: Staff files reviewed to verify that all employees have completed reference checks. No residents have been affected by the alleged deficient practice. Reference checks have been completed for the employee who did not have references completed upon re-hire. 3.MEASURE TO PREVENT RECURRENCE: The Executive Director and/or Business Office Manager will review employee records to verify that reference checks were completed prior to a new hire or re-hire. Reference	03/22/2020

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			checks have been completed for the employee who did not have references completed upon re-hire. 4.MONITORING SYSTEMS IN PLACE An audit will be conducted by the Executive director or business office manager to verify that current employees and new-hires reference checks have been completed using the State form 5440 each time there is new hire or re-hire. (attachment 1) 5.TO PREVENT RECURRENCE: State Form 5440 will be used to verify refences checks have been completed prior to date of hire and the 5440 will be reviewed monthly as part Quality Assurance, 6.SYSTEM CHANGES COMPLETED: 3/22/2019	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel,			

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	this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.			
	Based on interview, and record review, the facility failed to ensure dementia training was completed for 4 out of 5 employee's reviewd for dementia training. Findings include: A review of employee records on 3/4/2020 at 2:15 p.m., indicated the following: Employee 3's record was missing a completed 3 hours of annual dementia training. Employee 6's record was missing a completed 6 hours of initial dementia training. Employee 11's record was missing a completed 3	R 0120	R 120 Personnel Dementia 1.CORRECT ACTIONS FOR AFFECTED RESIDENTS: The employees identified have completed their required dementia. All department heads were in-serviced on the state requirements for dementia training. 2.METHODS FOR IDENTICATION OTHER RESIDENTS POTENTIALLY AFFECTED RESIDENTS: The Executive Director and/or the Department head will review all employees to ensure that meet their required dementia training in Relias and document completion using State	03/21/2020

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	hours of annual dementia training. Employee 12's record was missing a completed 6 hours of initial dementia training. During an interview on 3/4/2020 at 2:51 p.m., the ED (Executive Director) indicated she prints a list out of what employees are to do from the Relias training computer system, then she gives those lists to the employees department head. The facility provided no policy for dementia training.		form 5440 (attachment #1) . No residents were affected by this alleged deficient practice. 3.MEASURE TO PREVENT RECURRENCE: The Executive Director and/or designee will verify compliance of Relias dementia training using State form 5440. 4.MONITORING SYSTEMS IN PLACE An audit will be conducted by the Executive director or business office manager to verify that current employees have state required training has been completed using the State form 5440 each time. 5. TO PREVENT RECURRENCE: The Executive Director will monitor the completion of the dementia training using State Form 5440 and will view the document as part of the monthly QA process 6. SYSTEM CHANGES COMPLETED: 3/22/2020	
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter			

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	of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on interview, and record review, the facility failed to ensure a employee's professional license was current and completed for 1 of 5 employee records reviewed. Findings include: A review of employee professional licenses on 3/4/2020 at 2:15 p.m., indicated contracted Cosmetologist 10 had an expired license. During an interview on 3/4/2020 at 4:30 p.m., the ED (Executive Director) indicated they had problems in the past with her license and they got it worked out through the licensing agency last year. The ED indicated she had no documented information. The ED further indicated the beautician was scheduled on Tuesday's and continued to provide services in the facility salon.	R 0123	R 123 Personnel - Beautician 1.CORRECT ACTIONS FOR AFFECTED RESIDENTS: The Beautician has been pulled from practicing until she can provide a current license. 2. METHODS FOR IDENTICATION OTHER RESIDENTS POTENTIALLY AFFECTED RESIDENTS: No residents were affected by this alleged deficiency. Another licensed beautician is taking her appointments until the prior Beautician can provide a current license. MEASURE TO PREVENT RECURRENCE: They will be maintained a copy of the current beautician's license in the beauty shop. A copy of the current license will be kept in the license book. 4.MONITORING SYSTEMS IN PLACE The Executive Director and/or Business Office Manager will monitor review the State Form 5440 (attachment #1) at the	03/21/2020

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			beginning of each month to verify the working beauticians have a current license. 5.TO PREVENT RECURRENCE: The ED to a monthly audit of license book and State Form 5440 as part of the monthly QA process 6. SYSTEM CHANGES COMPLETED: 3/22/2020	
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview, and record review, the facility failed to ensure the grounds were maintained in clean condition, which had the potential to affect the 58 residents who resided in the facility. Findings include: An observation from the 500 hall back windows	R 0148	R 148 Sanitation & Safety - Grounds 1.CORRECT ACTIONS FOR AFFECTED RESIDENTS: The maintenance assistant immediately cleaned the dumpster area and picked up cigarette butts on the facility grounds. The	03/21/2020

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	on 3-4-2020 at 9:50 a.m., indicated there were several black bags and debris around the 2 dumpsters. On 3-4-2020 at 10:42 a.m., an observation outside at the area where the dumpsters were kept in the far back of the facility, indicated there was a stationary fence around the 2 dumpsters on 3 sides. There were 2 gates in front of the dumpsters, which were opened and secured opened. There was a large pile of black trash bags to the right of the dumpster on the right, inside the fenced area. It was not possible to count how many black trash bags were in the pile, but some were ripped open. There were smashed cups, white, wet paper trash, wet and opened incontinence briefs, a multitude of blue/purple gloves, wet cardboard, food wrappers, plastic bags, cigarette package, food packages and dirt and debris mixed in with all this trash. The dumpster on the left had wet, flattened cardboard around it and some of the blue/purple gloves on the ground. In the vegetation and evergreen area outside of the fenced in dumpster area and along the landscaped area along the curbs, there were plastic bags, styrofoam, blue/purple gloves, cotton tipped applicator, wet paper napkins and an assortment of debris stuck in the vegetation and on the mulch. At the right of the dumpster area, there was a plastic cigarette debris disposal container observed. About 3 feet from the cigarette debris disposal container, there were at least a 100 white cigarette ends observed to be laying on the ground along the curb area. An observation of the dumpsters and area surrounding the dumpsters on 3-4-2020 at 2:27 p.m., indicated the black trash bags and incontinent briefs had been picked up. There was still wet cardboard, food wrappers, plastic		Housekeeping supervisor, Maintenance Director, and Maintenance assistant have been in-serviced on grounds maintenance including dumpster areas and cigarette butts on the grounds. The Maintenance Employees have been in-serviced on Routine Community Inspections Policy (attachment #4) 2. METHODS FOR IDENTICATION OTHER RESIDENTS POTENTIALLY AFFECTED RESIDENTS: No residents were affected by this alleged deficient action and no accidents or injuries noted regarding any environmental hazards. 3. MEASURE TO PREVENT RECURRENCE: In the event of the absence of the Maintenance Director, the maintenance assistant will be responsible for maintaining the grounds including addressing any cigarette butts or trash on the facility grounds. 4.MONITORING SYSTEMS IN PLACE The maintenance assistant will verify that the facility grounds are maintained in good condition including the dumpster areas and cigarette butts by documenting grounds maintenance had been conducted no less then 3x a week for 4 weeks, 2x a week for 8 weeks, 1x a week for 12 weeks. (attachment #2)	

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	silverware and the blue-purple gloves around the dumpsters. There was still trash, consisting of the blue-purple gloves, styrofoam, plastic bags and paper observed in the brush, evergreen trees and the landscaping to the left of the dumpsters. There was still white cigarette ends observed next to the curb in the grass about 3 feet away from the cigarette debris receptacle which was to the right of the dumpsters. The Maintenance Director arrived on 3-4-2020 at 10:14 a.m. and indicated he had been off for 2 months for illness. The Maintenance Director on 3-4-2020 at 10:22 a.m., was asked about the trash bags around the dumpsters. The Maintenance Director indicated the second and third shift staff were not getting the bags in the dumpster. He indicated there were cameras and staff had been advised if they were on camera not getting the trash bags inside the dumpster and leaving them on the ground outside the dumpster, they would be written up. He indicated that was not followed through. He indicated he watched on camera 3 staff each throwing a trash bag and trying to make the bag land inside the dumpster. When the trash bag did not make it inside the dumpster, the staff left the bags lay outside the dumpster. He indicated this happened on third shift. An interview with the Maintenance Director on 3-4-2020 at 12:30 p.m., indicated Van Driver/Maintenance Assistant 3 cleaned up the area around the trash dumpsters. An interview with Housekeeper 4 on 3-4-2020 at 3:20 p.m., indicated housekeeping services were on first shift. She indicated the trash she collected on her shift went into her housekeeping		5. TO PREVENT RECURRENCE: The Executive Director and or the Housekeeping Supervisor will inspect the grounds to ensure that grounds in good condition by documenting on the Community Inspection Tool for the ED and Housekeeping supervisor for 3x a week for 4 weeks, 2x a week for 8 weeks, 1x a weeks for 12 weeks. (Attachment #3) The tool will be reviewed at the monthly QA process. 6. SYSTEM CHANGES COMPLETED: 3/22/20	

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	cart bin unless there was soiled trash with incontinence products inside, then she would place it in the CNA (Certified Nurse Aide) bin in the housekeeping closet. She indicated at the end of her shift, she would take out the trash to the dumpster and put it inside the dumpster. She indicated if she would not get the bag inside the dumpster, she would pick it up off the ground and place it inside the dumpster. She indicated she had not seen staff from the healthcare facility next door put trash in this facility's dumpsters. She indicated the CNAs on the second and third shifts were responsible to take the trash out to the dumpsters on their shifts. An interview with CNA 5 on 3-4-2020 at 3:23 p.m., indicated she worked second shift and will take all the trash collected on her shift in her area out to the dumpster. She indicated if she missed getting the trash bag inside of the dumpster, she would pick it up and put it inside the dumpster, which was the respectful thing to do. The CNA indicated she had not seen anyone from the healthcare facility next door use this facility's dumpsters. An interview with the Executive Director on 3-4-2020 a 4:43 p.m., indicated she was going to make a daily checklist for maintenance to ensure the dumpster area was clean. She indicated visitors and family of residents also used the smoking areas. The resident list by room number was provided by the Executive Director at entrance on 3-3-2020, and indicated there were a total of 58 residents in the facility. A current undated policy, "Resident Smoking" was provided by the Executive Director on			

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	3-4-2020 at 11:50 a.m. The policy indicated, "...Smoking is prohibited within the community...smoking is allowed on the grounds with in the appropriate/designated smoking areas...the areas allowed for smoking for residents is in the courtyard end, and staff designated smoking is in the back of the community outside the kitchen entrance...Appropriate fire rated receptacles will be provided in designated smoking areas for refuse...policy will be enforced. A policy for trash/grounds upkeep was requested but not provided.			
R 0272 Bldg. 00	410 IAC 16.2-5-5.1(e) Food and Nutritional Services - Deficiency (e) All food shall be served at a safe and appropriate temperature. Based on observation, interview and record review, the facility failed to ensure food temperatures were monitored for 1 of 1 dining observations in the main dining room. The deficient practice had the potential to affect at least 19 of the 58 residents in the facility who were observed to have eaten in the main dining room. Findings include: On 3/3/2020 at 11:40 a.m., the kitchen was observed. Cook 2 was observed to check temperatures of the foods to be served at the lunch meal. She was observed to check the foods on the steam table which included meat loaf, macaroni and cheese and brussel sprouts. The Food Service Manager (FSM) was observed to document the temperatures on the food temp log as Cook 2 read them aloud. A large crock pot was observed in the beverage service area of the kitchen. After Cook 2 obtained the temperatures from the steam table, she was interviewed if she	R 0272	R 272 Food and Nutrition -Temps of Soup 1.CORRECT ACTIONS FOR AFFECTED RESIDENTS: The DSM immediately added soups on the weekly temperature record. (attachment 5). All cooks have been in-serviced on recording food temperatures. 2. METHODS FOR IDENTICATION OTHER RESIDENTS POTENTIALLY AFFECTED RESIDENTS: There have been no residents affected by this alleged deficient practice and there have been no residents with food related illness or concerns. 3.MEASURE TO PREVENT RECURRENCE: The cooks will record food temps using the weekly Temperature Record at each meal including soup.	03/21/2020

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	had any other food temperatures to check. She indicated "no." She was queered as if she had checked the temperature of the soup and she indicated she would check it now. Cook 2 was observed to obtain a temperature of the soup of 168 degrees Fahrenheit (F). On 3/3/2020 at 11:50 a.m., the food temperature log was reviewed for the month of March 2020. Documentation was lacking on the log of the soup temperatures. On 3/3/2020 at 11:55 a.m., the FSM was interviewed regarding the logging of the soup temperatures. She indicated they had to add the temperatures at the bottom of the log. Documentation was lacking on the current temperature log of any soup temperatures. On 3/3/2020 at 1:50 p.m., the FSM was interviewed. She indicated the soup was put in the crock pot around 10:30 a.m. and would be served around 11:45 a.m. She indicate the noon meal service was usually completed by 12:30 p.m. - 12:45 p.m. She indicated all the residents at the facility eat food from the kitchen. She indicated the temperature of the soup should be checked prior to service. She indicated soup was provided for both the noon and evening meal daily unless the soup was served as an entree. On 3/3/2020 at 2:33 p.m., the FSM provided a current, undated copy of the facility policy and procedure for Therapeutic Diets. The policy and procedure included but was not limited to, the following: "Food must be served at appropriate temperatures...Hot foods should be served at the following temperatures to ensure that they arrive at the table hot...Hot soup...140 F - 190 F.		4.MONITORING SYSTEMS IN PLACE The Dietary Manger will review the Weekly Temperature record 3x a week for 4 weeks, 2x a week for 8 weeks, 1x a week for 12 weeks to verify that food temperatures are within required guidelines, including soup. (attachment #6) 5. TO PREVENT RECURRENCE: As part of the monthly QA process the weekly Temperature Record reviewed to verify that food temperatures were recorded and within dietary guidelines. 6. SYSTEM CHANGES COMPLETED: 3/22/2020	

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(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
	On 3/3/2020 at 3:20 p.m., the FSM provided copies of the "Weekly Temperature Record' for the time period 1/5/2020 to the current date. Of the 59 days provided, documentation was lacking on all 59 days of the temperature of the soup.			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure dishwasher temperatures were monitored and/or maintained. This deficient practice had the potential to effect 58 of 58 residents in the facility who ate their meals from the facility kitchen. Findings include: On 3/3/2020 at 1:05 p.m., the dishwasher machine was observed running. The wash temperature illuminated on the display screen indicated a temperature of 161 degrees. Dietary Staff 6 was observed to have prepared dishes to be put into the dishwasher. At 1:06 p.m., Dietary Staff 6 was interviewed. She indicated she was unsure if the dishwasher sanitized the dishes by heat or chemical. On 3/3/2020, at 1:09 p.m., Cook 2 was observed by the dishwasher. The wash cycle of the dishwasher was observed to have been completed and the display screen illuminated a rinse temperature of 176 degrees (Fahrenheit). The time from the wash temperature until the final rinse temperature was displayed was observed to have been no more than 5 seconds. The dishes, which	R 0273	1.CORRECT ACTIONS FOR AFFECTED RESIDENTS: Dietary employees have been in serviced on the required dishwasher temps, how to use the Ware Washing Temperature Log, and to do a second dish washing cycle if the 1st cycle does not reach temp and to record the second cycle if it is the one that reaches the required temperature, and to notify the dietary manager if unable to reach the required temps after the 2nd cycle. 2. METHODS FOR IDENTICATION OTHER RESIDENTS POTENTIALLY AFFECTED RESIDENTS: No residents have been negative affected by this alleged deficient practice. There have been no food related illnesses nor concerns voiced. 1.MEASURE TO PREVENT RECURRENCE: Dietary staff will document dishwashing temperatures using the Ware	03/21/2020

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	had just been observed to run through the dishwasher, remained in the rack on the counter. They were not observed to have been run through the dishwasher again. On 3/3/2020 at 1:48 p.m., the "Ware Washing Temperature Log" dated 3/2020 was observed hanging on the wall in the dishroom and was reviewed. Documentation indicated the wash and rinse temperatures of the dishwasher had been obtained for breakfast, lunch and dinner daily. Documented on the bottom of the form indicated the following: "In order to provide a safe environment, this temperature log shall be monitored and filled out three times during our open operation (before breakfast dishes, lunch dishes, and the dinner dishes). The safe temperatures are as follows...wash cycle is 150 F or above and the rinse cycle will be 180 F or above...If at any time the temperatures are out of the stated temperatures, the problem must be reported to the supervisor immediately..." On 3/3/2020 at 2:50 p.m., the FSM was observed to run the dishwasher again, without dishes. The wash temperature was observed to reach 163 F and the highest rinse temperature reached was 175 F. The FSM indicated she would call the service provider. On 3/3/2020 at 1:10 p.m., Cook 2 was interviewed. She indicated the rinse cycle "was quick." On 3/3/2020 at 1:47 p.m., the Food Service Manager (FSM) was interviewed. She indicted the dishwasher sanitized the dishes by heat. She indicated the wash temperature was to be over 150 degrees F and the rinse temperature was to be over 180 degrees F. A label on the dishwasher was observed to indicated also, the wash		Washing Temperature Log. (attachment #8) 4.MONITORING SYSTEMS IN PLACE 1.An audit will be conducted by the Dietary Services manager using the Ware Washing Temperature Log Audit tool for 3x a week for 4 weeks, 2x a week for 8 weeks, 1x a week for 12 weeks to verify that dishwashing temperatures are within required guidelines. (attachment #7) 5. TO PREVENT RECURRENCE: As part of the monthly QA process the Ware Washing Temperature Log audit tool will reviewed by the Dietary Services Manager or the Executive director to verify that food temperatures were recorded and within dietary guidelines. 1.6. SYSTEM CHANGES COMPLETED: 3/22/2020	

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	temperature was to be at least 150 degrees and the rinse temperature was to be at least 180 degrees. On 3/3/2020 at 1:49 p.m., the following temperatures, to date, were observed documented on the Ware Washing Temperature Log: Breakfast: all 3 rinse cycles had a temperature of 161 F; lunch had rinse cycles with temperatures of 170, 175 and 174; and the dinner rinse cycle had two temperatures documented on 170 and 171 (the dinner wash cycle had not yet occurred for 3/3/2020). On 3/3/2020 at 1:50 p.m., the FSM was interviewed regarding the dish washer temperatures observed on the Ware Washing Temperature Log. She indicated "Oh, that's not right." She indicated she thought the staff was not documenting the correct temperatures of the dishwasher. She indicated the dishwasher was set for the wash cycle to run at 4 minutes. She indicated she thought the staff was not documenting the highest wash and rinse temperatures. At this time, the FSM ran the dishwasher cycle again. The wash temperature was observed to be 158 F and the rinse temperature was observed to be 181 degrees F. The FSM indicated (name of dishwasher service company) comes to the facility once a month to service and monitor the dishwasher. She indicated she was not aware of any problems with the dishwasher and had not been made aware of the temperatures below recommended levels. The FSM indicated she had contacted the (name of dishwasher service company) today and they indicated the rinse cycle should take "about 10 seconds." On 3/3/2020 at 2:15 p.m., the FSM was interviewed. She indicated when the dishwasher temperatures were below recommended			

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	temperatures, the staff was to rerun the load until the temperatures were within the acceptable range. If the dishwasher temperatures were out of the acceptable range, the staff was to notify her immediately. The FSM indicated the (name of dishwasher service company) had been at the facility recently and checked the machine. She indicated he had repaired the heating booster on the dishwasher about a month ago. On 3/3/2020 at 2:55 p.m., Dietary Staff 6 and Dietary Staff 7 were interviewed. They indicated all staff helps out with doing dishes. They indicated if the dishwasher temperatures did not reach desired levels, they were to run the dishwasher again. If the dishwasher still did not reach desired temperature levels, they were to notify the FSM immediately. On 3/4/2020 at 9:55 a.m., the FSM was interviewed. She indicated she had contacted the dishwasher service provider and was instructed if the dishwasher temperature were not meeting required levels, they were to run the dishwasher through another cycle. If, after the repeated cycle, the dishwasher temperatures do not meet required temperatures, notify the dishwasher provider. The FSM indicated she personally checked the dishwasher temperature last evening and it tested fine. She indicated the wash temperature for the dinner meal was 160 degrees and the rinse temperature was 186 degrees. She indicated again, she felt the dishwasher was working acceptable, but the staff was not documenting the actual highest temperature for the wash and rinse cycles. On 3/4/2020 at 10:20 a.m., the Dietary Staff 8 was interviewed. She indicated she had checked the temperature of the dishwashers. She indicated the temperature she documented on the Ware			

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	Washing Temperature log was the highest temperature reached for the wash and rinse cycle. On 3/3/2020 at 2:33 p.m., the current, undated, policy and procedure for Washing and Sanitizing Dishes/Utensils was received from the FSM. The policy and procedure included, but was not limited to, the following: Sanitization is a process to destroy any germs that may cause an illness. Washing and sanitizing dishes and utensils are important procedures in order to prevent the spread of disease. Follow the operating instructions by the manufacturer of the machine. These instructions are posted on the machine. Ensure that the machine reaches the proper temperatures (the wash temperature must be a minimum of 140 degrees F and the rinse water must reach 180 F. All employee partners must be trained on how to use equipment in the kitchen and/or dining room prior to use. On 3/4/2020 at 2:00 p.m., the Nutritional Service Orientation records for Cook 2 and Dietary Staff 6 were reviewed. Both records indicated they had been oriented on "temping (checking food temperatures) food and recording temps (temperatures)" and "taking dish-room temperatures." Cook 2 signed her orientation form 7/3/2019 and Dietary Staff 6 signed her orientation form on 3/4/2019. The form indicated "...I understand that I've been trained..."			
R 0295 Bldg. 00	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, interview and record review, the facility failed to ensure a medications	R 0295	R 295 Pharmaceutical – Safety of resident medications for residents	03/21/2020

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	were maintained in a safe and secure manner for a resident who had not been assessed to self medicate for one of 20 residents reviewed. Resident 1 Findings include: On 3/3/2020 at 10:00 a.m., LPN was interviewed. She indicated Resident 1 was alert, oriented and reliable for interview. On 3/3/2020 at 11:20 a.m., Resident 1 was interviewed in her room. She was observed sitting in her recliner with a table at her side. On the table at chair side, was observed to be a medication (med) up with 2 pills in it. The pills were observed to be each a tan color and oblong in shape. The 2 pills appeared to be 2 different medications as they were a slightly different color from each other. On 3/3/2020 at 11:21 a.m., Resident 1 was interviewed. She indicated the facility gave her her medications as she "pays for that service." She indicated these medications had been brought to her room by Qualified Medication Aide (QMA) 9, this morning about 8:00 a.m. The resident indicated she had a bad morning, spilled her coffee and had not taken her pills. She indicated she told QMA 9 she would take her pills. On 3/3/2020 at 12:04 p.m., LPN 1 was observed to take residents their medications in the dining room. LPN 1 was observed to stand directly beside the resident at the dining room table until the resident had taken their medications. At that point, LPN 1 was observed to leave the resident's side.		who do note self-administrate. 1.CORRECT ACTIONS FOR AFFECTED RESIDENTS: Licensed Nurses and QMA's have been in- serviced on medication pass including that residents who do not self-administer meds must have the Licensed Nurse or QMA observe that the resident take the medication as prescribed. In addition, departments & staff members have been in-serviced, if they observe medications unattended in common area or resident room to notify the Wellness Director and/or the Executive Director. If the Wellness Director or Executive Director is not available notify the charge nurse so he or she can notify the Wellness Director or the Executive Director. All residents who self-administrator will be screened to verify that they can safely administer their own medications. 2. METHODS FOR IDENTICATION OTHER RESIDENTS POTENTIALLY AFFECTED RESIDENTSL 1.MEASURE TO PREVENT RECURRENCE: No residents have been affected by this alleged deficiency. There have been no residents with negative side effects in relation to medication administration. 4.MONITORING SYSTEMS IN PLACE The Wellness Director or Designee will round no less then	

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	On 3/3/2020 at 12:05 p.m., LPN 1 was observed to take Resident 1 her medication to her in the dining room. Prior to LPN 1 giving Resident 1 her medication, she was queered regarding the medication. LPN 1 was made aware Resident 1 had been observed earlier in the morning, to have a medication cup at her chair side in her room, which was observed to contain two oblong tan colored pills. The medication LPN 1 currently had in the medication cup for Resident 1 was an orange tablet. LPN 1 indicated this medication was hydralazine (medication to treat high blood pressure). On 3/3/2020 at 12:07 p.m., LPN 1 returned to Resident 1's table. Resident 1 made LPN 1 aware she had medication in her room that she had not taken earlier in the day. Resident 1 indicated to LPN 1 she had spilled her coffee earlier in the morning and had not taken her medication at that time. Resident 1 indicated to LPN 1 she had taken her medication later this morning. On 3/3/2020 at 12:08 p.m., LPN 1 was observed in the med room and was interviewed. LPN 1 indicated Resident 1 had told her in the dining room today at the noon meal, she had a bad morning and had not gotten around to taking her morning pills earlier, but she just did. LPN 1 indicated she had given the resident all her morning pills this morning at 8:30 a.m. She indicated when she had been in Resident 1's room this morning, the resident was coming out of the bathroom at that time and took her pills then. LPN 1 indicated she didn't notice the pills on the resident's chair beside her table as the resident was in the bathroom/bedroom area and her chair and table beside, were in the living room area.		3x a week for 4 weeks, 2x a week for 8 weeks, 1x a week for 12 weeks to verify that residents' medications have been passed and residents have received and taken their medication. (attachment #9) 5. TO PREVENT RECURRENCE: As part of the monthly QA process the Executive Director and or Director of Nursing will review the Medication Management tool has been completed and that residents had received and taken their medications. 6. SYSTEM CHANGES COMPLETED: 3/22/2020	

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	On 3/3/2020 at 12:08 p.m., the medication administration record (MAR) for Resident 1 was reviewed. Documentation indicated LPN 1 had administered 10 medications to the resident this morning for the 8:00 a.m. dose. Documentation was lacking of QMA 9 having administered medications to Resident 1 on 3/3/2020 for the 8:00 a.m. Documentation was lacking on the MAR 3/3/2020 of refusals for the resident's medications for the 6:00 a.m. dose and/or the 8:00 a.m. dose. On 3/4/2020 at 8:45 a.m., the Executive Director (ED) and Wellness Director (WD) were interviewed. The WD indicated the facility was to pass Resident 1's medication and she should not have self administered her own medications. She indicated the resident had not been at the facility for 6 months yet and on her admission evaluation, it was determined the facility would administer the resident's medications. The WD indicated when medications were passed to Resident 1, the staff should remain with the resident and observed the resident consumed the medication. The WD indicated the medications should not have been left at the resident's room. On 3/4/2020 at 11:50 a.m., the WD provided a current, undated copy of the facility policy and procedure for "Employee Partner Procedures for Medication Assistance..." The policy and procedure included, but was not limited to, the following: "Only Employee Partners who are appropriately licensed or have been trained/delegated may assist with medications in the community...Be sure to observe the Resident taking his/her medication...Initial in the appropriate space on the Resident's Medication Administration Record (MAR) in the square for that day and time...if the resident refuses to take			

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	the medication, document the incident on his/her Medication Sheet...Notify the Wellness Director..."			
R 0304 Bldg. 00	410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on observation, interview and record review, the facility failed to ensure medications were maintained in a secure manner for 1 of 1 medication rooms observed. Findings include: On 3/3/2020 at 9:35 a.m., the Executive Director (ED) was observed to go the medication (med) room. The door to the medication room was opened and LPN 1 was observed to be sitting at a desk. On the desk was observed to be at least 6 medication cards and two prescription bottles. LPN 1 was directed by the ED to tour the facility. LPN 1 was observed to leave the medications on the desk, then closed the locked medication room door behind her. On 3/3/2020 at 10:04 a.m., LPN 1 was conducting a tour of the facility. The Sales Director was observed to approach LPN 1 and indicated "I need the keys because Lab is here." LPN 1 reached into her pocket and handed the Sales Director her "keys." The Sales Director was observed to walk down the hall towards the med room.	R 0304	R 304 Pharmaceutical 1.CORRECT ACTIONS FOR AFFECTED RESIDENTS: The meds were accounted for by the nurse and passed in accordance with the physician's order. 2. METHODS FOR IDENTICATION OTHER RESIDENTS POTENTIALLY AFFECTED RESIDENTS: MEASURE TO PREVENT RECURRENCE: All department in-serviced regarding only licensed nurses or QMA's can open the nursing station door. No residents were affected by this alleged deficiency. 4.MONITORING SYSTEMS IN PLACE The Wellness Director of Designee will round to verify that medication are not left unsecured and unattended in the nurses station or med cards and that only licensed clinical staff are opening	03/21/2020

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	On 3/3/2020 at 10:05 a.m., the medication room was observed with LPN 1. The door to the med room was observed opened with the Sales Director observed standing in the doorway. A female was observed sitting at the desk in the med room with the medication cards and two prescription bottles still observed on the desk, beside the female. On 3/3/2020 at 10:07 a.m., LPN 1 was interviewed. She indicated the female at the desk was from an outside lab source. The following pill cards were observed with the following number of pills in each card: Vitamin D (3 pills); Cardizem (3 pills); Iron (2 pills); Aspirin (2 pills); Prilosec (1 pill) and Vitamin B 12 (3 pills). The prescription bottles were labeled and contained the following number of pills: Calcium (10 pills) and Synthroid (4 pills). On 3/3/2020 at 2:04 p.m., LPN 1 was interviewed. She indicated she was reordering meds earlier this morning and that's why they were on the desk. On 3/3/2020 at 3:00 p.m., the ED was interviewed. She indicated she had told the Sales Director to go get the keys from LPN 1 as the Lab staff was at the facility to draw labs. She indicated she didn't want to delay the Lab in performing their duties and didn't want to interrupt the tour with LPN 1. On 3/4/2020 at 8:45 a.m. the ED and Wellness Director (WD) were interviewed. The WD was made aware LPN 1 was observed to give the medication (med) room keys to the Sales Director on 3/3/2020 at 10:04 a.m. She was also made aware of the lab personnel observed sitting at the desk in the med room, with medication cards (with pills in them) and two prescription bottles (also with pills in them) observed to have been on the same desk. The medications on the desk were		nursing station door. This will be documented on the Medication Storage Audit with rounds 3x weekly for 4 weeks, 2x for 8 weeks, and 1x weekly for 12 weeks. (attachment #10) 5. TO PREVENT RECURRENCE: The Executive Director and wellness Director will review the Medication Storage Audit at monthly QA to verify completion of the audit and that only licensed nurses are opening nursing station door and that medications are secure in the nurses stations and medication carts. 6. SYSTEM CHANGES COMPLETED: 3/22/2020	

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	unsecured. The WD indicated LPN 1 should not have given the med room keys to the Sales Director and the lab personnel should not have been in the medication room unsupervised by a licensed nurse and/or licensed staff to pass medications. She indicated LPN 1 indicated she thought it was acceptable to give the keys to the Sales Director, since he was in a management position. On 3/4/2020 at 10:29 a.m., the WD provided a current, undated copy of the facility policy and procedure for "Storage of Medications" The policy and procedure included, but was not limited to, the following: "All medications stored by the Community must be maintained in a...locked stationary container or area...Do not leave medications out on the counter in the medication room or unattended outside the medication room. All medications should be stored in the appropriate location when not being used...:			