PRINTED: 09/19/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. building <u>00</u>			COMPLETED	
			B. W	ING		08/22/2023		
				CED FEE	A DDDDEGG CHTW CTA TE TID COD			
NAME OF P	ROVIDER OR SUPPLIER	_			ADDRESS, CITY, STATE, ZIP COD			
DEMADE	00000N0 400	NOTED LIVING AND MEMORY			DEMAREE ROAD			
DEMARE	E CRUSSING ASS	SISTED LIVING AND MEMORY (AKE	GREE	NWOOD, IN 46143			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
R 0000								
Bldg. 00								
	This visit was for a	State Residential Licensure	R 0	000	This Plan of Correction is			
	Survey. This visit is	ncluded the Investigation of			submitted under regulations			
	Complaint IN00414	999.			applicable to long term care			
					providers. This Plan of Corre	ction		
	Complaint IN00414	999 - No deficiencies related to			is not to be construed as an			
	the allegations are c	ited.			admission or agreement with	the		
					findings and conclusions in the	е		
	Survey dates: Augu	ıst 21 and 22, 2023			Statement of Deficiencies. Th	ie		
					preparation/ submission and/o	or		
	Facility number: 014079				execution of this Plan does no	ot		
					constitute agreement by the			
	Residential Census:	57			facility that the surveyor's find	ings		
					or conclusions are accurate, t	hat		
	These State Residen	itial Findings are cited in			the findings constitute a			
	accordance with 410	0 IAC 16.2-5.			deficiency, or that the scope a	ınd		
					severity regarding any of the			
	Quality review com	pleted August 25, 2023.			deficiencies are correctly appl	ied.		
					Submission of this Plan is			
					evidence of compliance.			
R 0217	410 IAC 16.2-5-2(, ,						
	Evaluation - Defici	<u> </u>						
Bldg. 00		pletion of an evaluation, the						
		opriately trained staff						
		entify and document the						
	· ·	vided by the facility, as						
	follows:							
	• •	ffered to the individual						
	resident shall be a	ppropriate to the:						
	(A) scope;							
	(B) frequency;							
	(C) need; and							
	(D) preference;							
	of the resident.							
	• •	ffered shall be reviewed and						
		riate and discussed by the						
	resident and facilit	y as needs or desires						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Marlee Oleksy Executive Director 09/14/2023

Any defiency statement 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		î ´			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETE			ETED	
			B. W	ING		08/22/	/2023
		<u> </u>		CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			EMAREE ROAD		
DEMADE	E CDOSSING ASS	SISTED LIVING AND MEMORY CA	DE		IWOOD, IN 46143		
DEMARE	E CRUSSING ASS	BISTED LIVING AND MEMORY CA	NE.	GREEN	WOOD, IN 46143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	change. Either the	e facility or the resident may					
	request a service	plan review.					
	(3) The agreed up	oon service plan shall be					
	signed and dated	by the resident, and a copy					
	of the service plar	n shall be given to the					
	resident upon req	uest.					
	• •	on and documentation of					
	services provided	is needed if evaluations					
	·	initial evaluation indicate					
	no need for a cha	_					
	, ,	on of medications or the					
	•	ential nursing services, or					
		licensed nurse shall be					
		cation and documentation of					
	the services to be	•					
		view and interview, the facility	R 0217		o Community's Health and		10/02/2023
		service plans were signed and			Wellness Director, or their		
	dated by the resider				designee, will revisit the service		
	-	of 6 residents reviewed for			plans of residents reviewed du	_	
		dent 76, Resident 82, Resident			this survey. Service plans will	be	
	84, Resident 89, Re	esident 95, Resident 99)			reviewed and signed with the		
					resident or responsible party,	as	
	Findings include:				appropriate.		
					o Community's Health and		
		20 p.m., Resident 76's clinical			Wellness Director, or their		
		d. The Semi-Annual Evaluation			designee, will conduct an aud		
		ated 3/29/23, lacked a resident			current resident service plans	tor	
	or responsible party	signature.			signature. Current resident		
	2 0 9/21/22 / 11	00 B :1 (62) 1: : 1			service plans without signatur		
		:00 a.m., Resident 82's clinical			be reviewed and signed with t		
		d. The Semi-Annual Evaluation			resident or responsible party,	as	
	· ·	ated 3/27/23, lacked a resident			appropriate.		
	or responsible party	signature.			o Going forward, upon		
	2 On 9/21/22 at 11	:30 a.m., Resident 84's clinical			completion of evaluation and	_	
					creation of a resident's service		
		d. The Semi-Annual Evaluation			plan, the community's Health	and	
		ated 4/5/23, lacked a resident or			Wellness Director, or their		
	responsible party si	gnature.			designee, will review with the		
	4 0 0/01/02 / 11	.45 D::1+ 90! 1' ' 1			resident or responsible party,		
	4. On 8/21/23 at 11	:45 a.m., Resident 89's clinical			obtain signature/ date. A sign	ea	

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record was reviewed. The Semi-Annual Evaluation and Service Plan, dated \$23/23, lacked a resident or responsible party signature. 6. On 8/21/23 at 12:30 p.m., Resident 99's clinical record was reviewed. The Semi-Annual Evaluation and Service Plan, dated 3/22/23, lacked a resident or responsible party signature. 6. On 8/21/23 at 12:30 p.m., Resident 99's clinical record was reviewed. The Initial Evaluation and Service Plan, dated 3/22/23, lacked a resident or responsible party signature. During an interview on 8/22/23 at 9:20 a.m., the ED (Executive Director) and the Director of Health and Wellness indicated the Semi-Annual Evaluations and Service Plans each lacked a resident or responsible party signature. On 8/22/23 at 12:30 p.m., the ED provided a facility policy titled "Evaluation Schedule", dated 2/2/23, and indicated that for all types of resident evaluations, including but not limited to the pre-admission evaluation, 6-month evaluation, and change of condition evaluation and service plan within 7 days of completion of evaluation. Signed copy of evaluation to be maintained in resident's chart." TAG and dated copy of the evaluation will be maintained in the resident's wellness file. The community's Executive Director, and of their designee, will complete random monthly audils for six resident sevice plans. Any deviation from compliance will be addressed promptly. The community's Executive Director, or their designee, will complete random monthly audils for six resident sevice plans. Any deviation from compliance will be addressed promptly. The community's Executive Director, or their designee, will complete random monthly audils for three months. Any deviation from compliance will be addressed promptly. The community's Executive Director, or their designee, will complete random monthly audils for six resident sevice plans. Any deviation from compliance will be addressed promptly. The community is Executive Director, or their designee, will complete random monthly audils for six resident sevice pl	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00	COMPLETED 08/22/2023
PREFIX TAG REGULATORY OR LSC IDENTIFYING PROMATION record was reviewed. The Semi-Annual Evaluation and Service Plan, dated \$5/3/23, lacked a resident or responsible party signature. 5. On 8/21/23 at 12:00 p.m., Resident 95's clinical record was reviewed. The Semi-Annual Evaluation and Service Plan, dated \$5/2/23, lacked a resident or responsible party signature. 6. On 8/21/23 at 12:30 p.m., Resident 99's clinical record was reviewed. The Semi-Annual Evaluation and Service Plan, dated \$7/2/23, lacked a resident or responsible party signature. During an interview on 8/2/23 at 9:20 a.m., the ED (Executive Director) and the Director of Health and Wellness indicated the Semi-Annual Evaluations and Service Plans each lacked a resident or responsible party. On 8/22/23 at 12:30 p.m., the ED provided a facility policy titled "Evaluation Schedule", dated 2/2/23, and indicated the Yell of the pre-admission evaluation, 6-month evaluation, and change of condition evaluations, "residented revaluations, including but not limited to the pre-admission evaluation, 6-month evaluation, and change of condition evaluation, s."residented review of evaluation for evaluation of evaluation for evaluation for evaluation for evaluation for evaluation for evaluation from compliance will be addressed promptly. R 0273 410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas			1255 D	EMAREE ROAD	
and Service Plan, dated 5/23/23, lacked a resident or responsible party signature. 5. On 8/21/23 at 12:00 p.m., Resident 95's clinical record was reviewed. The Semi-Annual Evaluation and Service Plan, dated 3/22/23, lacked a resident or responsible party signature. 6. On 8/21/23 at 12:30 p.m., Resident 99's clinical record was reviewed. The Initial Evaluation and Service Plan, dated 5/27/23, lacked a resident or responsible party signature. During an interview on 8/22/23 at 9:20 a.m., the ED (Executive Director) and the Director of Health and Wellness indicated the Semi-Annual Evaluation and Service Plans aceh lacked a resident or responsible party signature and each one should have been signed and dated by the resident or the responsible party. On 8/22/23 at 12:30 p.m., the ED provided a facility policy titled "Evaluation Schedule", dated 2/2/23, and indicated it was the policy currently being used by the facility. A review of the policy indicated that for all types of resident evaluations, including but not limited to the pre-admission evaluation. Semonth evaluation, and change of condition evaluation and service plan within 7 days of completion of evaluation. Signed copy of evaluation to be maintained in resident's chart." Will be maintained in the resident's wellness file. The community's Executive Director, and or their designee, will complete random monthly audits for six resident seach month over the course of three months to review signature. The community's Executive Director, or their designee, will complete random months to review signature. The community's Executive Director, or their designee, will complete random months to review signature. The community's Executive Director, or their designee, will complete random months to review signature. The community's Executive Director, or their designee, will complete random months or review signature. The community's Executive Director, or their designee, will complete random months or review signature. The community's Executive Director, or	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
Food and Nutritional Services - Deficiency Bldg. 00 (f) All food preparation and serving areas		and Service Plan, dated 5/23/23, lacked a resident or responsible party signature. 5. On 8/21/23 at 12:00 p.m., Resident 95's clinical record was reviewed. The Semi-Annual Evaluation and Service Plan, dated 3/22/23, lacked a resident or responsible party signature. 6. On 8/21/23 at 12:30 p.m., Resident 99's clinical record was reviewed. The Initial Evaluation and Service Plan, dated 5/27/23, lacked a resident or responsible party signature. During an interview on 8/22/23 at 9:20 a.m., the ED (Executive Director) and the Director of Health and Wellness indicated the Semi-Annual Evaluations and Service Plans each lacked a resident or responsible party signature and each one should have been signed and dated by the resident or the responsible party. On 8/22/23 at 12:30 p.m., the ED provided a facility policy titled "Evaluation Schedule", dated 2/2/23, and indicated it was the policy currently being used by the facility. A review of the policy indicated that for all types of resident evaluations, including but not limited to the pre-admission evaluation, 6-month evaluation, and change of condition evaluations, "resident/responsible party (both, if required by state) and community must sign evaluation and service plan within 7 days of completion of evaluation. Signed copy of		will be maintained in the reside wellness file. The community's Executive Director, and or their designed complete random monthly and for six residents each month of the course of three months to review signature/date within resident service plans. Any deviation from compliance will addressed promptly. The community's Executive Director, or their designee, will complete random monthly and for three months. Any deviation from compliance will be addressed promptly.	ent's e, will lits ver be
(excluding areas in residents ' units) are maintained in accordance with state and		Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are			

State Form Event ID: FJ1X11 Facility ID: 014079 If continuation sheet Page 3 of 10

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		r í	UILDING	onstruction 00	(X3) DATE COMPL 08/22	LETED	
	PROVIDER OR SUPPLIER	SISTED LIVING AND MEMORY C	ARE	1255 D	ADDRESS, CITY, STATE, ZIP COD EMAREE ROAD IWOOD, IN 46143		
(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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	standards, includi	nd safe food handling ng 410 IAC 7-24. on, interview, and record failed to ensure foods were	R 0	273	§ Current community culinary team members will be trained the Company's Personal	f	10/02/2023
	maintained and serv manner for 4 of 4 o covered while in the	yed in a sanitary and safe bservations. Staff hair was not e kitchen food preparation ods were not covered, labeled			Appearance Policy, inclusive hair covering requirements. Training will be evidenced by completion of an Inservice		
	or dated, and perish when past the use b Dietary Aide 4, Die	able foods were not discarded y date. (Dietary Aide 2, stary Aide 5, Cook 3, Cook 6, actor 8, and Dietary Manager)			Attendance Record, § New and future community culinary team members will b trained to the Company's Per	е	
	Findings include:				Appearance Policy in their pre-service orientation. § Community's Executive Ch	ef, or	
	_	kitchen tour with the Dietary 8/21/23 from 9:15 a.m. to 9:40 was observed:			their designee, will observe employees for compliance wi Company's Personal Appeara Policy on a daily basis.		
	the steamtable when being held and was the kitchen area. D have facial hair app	sobserved standing next to re the breakfast foods were observed walking throughout ietary Aide 2 was observed to roximately half inch in length. observed to not be covered.			Employees exhibiting non-compliance with this police will be addressed promptly. § The community's Executive Director, or their designee, with the community's executive processes.	e ill	
	- Cook 3 was obser the breakfast foods observed taking the	ved at the steamtable where were being held and was ending food temperatures.			complete random monthly au of for shifts per month for thre months. Any deviation from compliance will be addressed promptly.	ee	
	length, that were ob The braids were ob	approximately 3 inches in served below his chef's cap. served to not be covered.			o Covering, Dating, Labeling Element § Current community culinary medication team members wi trained to the Company's Foc	y and ill be	
	steamtable where the held and walking the The DM was observapproximately one	he breakfast foods were being broughout the kitchen area. Wed to have facial hair, inch in length, above and facial hair was observed to			Covering, Labeling, Dating, a Disposal Policy. by the Community's Executive Chef, their designee. Training will be evidenced by completion of a	nd or oe	

State Form Event ID: FJ1X11 Facility ID: 014079 If continuation sheet Page 4 of 10

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. B	MULTIPLE CO UILDING /ING	ONSTRUCTION 00	COME	E SURVEY PLETED 2/2023	
DEMAR	PROVIDER OR SUPPLIER	SISTED LIVING AND MEMORY (CARE	1255 D	ADDRESS, CITY, STATE, ZIP CO EMAREE ROAD IWOOD, IN 46143	OD .	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R I SC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	ECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE
TAG	not be covered. - Contractor 7 was the kitchen area neadish washing room approximately 2 inchair approximately 7's hair was observed. - Contractor 8 was the kitchen area neadish washing room approximately 1 incapproximately 3/4 in and below the lips. observed to not be conserved: A small and unlabeled. A contain unlabele	rigerator unit the following was bowl of pears was uncovered tiple cups of sour cream were ner of sliced lemons were ner of of tartar sauce with a /23. vation with the DM on 8/21/23 sident snack refrigerator, located ext to the resident dining room, de the refrigerator, the rved: obani, 5.3 ounce, yogurt rinted "use by date - June d on the container. The abel to indicated who the		TAG	Inservice Attendance R Current community medite team members will be to the Company's food collabeling, dating, and dispolicy by the community & Wellness Director, or designee. § New and future community and medication members will be trained Company's Food Cover Labeling, Dating, and Delicy in their pre-service orientation. § Community's Executive their designee, will community and dating of thems. § Community's Health Wellness Director, or the designee, will complete check of medication can ensure appropriate covering, and dating of fused for medication administration. § Community's Executive their designee, will observed appropriate covering, data approp	ecord. dication rained to vering, sposal y's Health r their munity n team d to the ring, bisposal ce ive Chef, or splete an orage areas overing, food and leir an internal rts to ering, food items ive Chef, or ering, food items ive Chef, or ering, food items an internal rts to ering, food items ive Chef, or erve ating, and within food ekly basis s. iance with ssed and	DATE

State Form Event ID: FJ1X11 Facility ID: 014079 If continuation sheet Page 5 of 10

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		l í	JILDING	instruction 00	(X3) DATE COMPL 08/22 /	ETED	
	PROVIDER OR SUPPLIER	SISTED LIVING AND MEMORY CA	ARE	1255 DI	ADDRESS, CITY, STATE, ZIP COD EMAREE ROAD IWOOD, IN 46143		
(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
140	item was, who it be and lacked a tight for the food items were the item was, who it item should be either items were to be compared to the kitchen area near noon foods were be walking near the dishad hair approximal.	longed to, and the use by date, itting cover. At that time, the DM indicated to be labeled to indicate what the belonged to, and when the errused or discarded. All food wered. The policy is observed to the me noon foods were being held walking throughout the kitchen 2 was observed to have facial half inch in length. The facial on not be covered. The policy is observed to have facial half inch in length. The facial on the covered. The policy is observed to have facial half inch in length. The facial on the covered. The policy is observed to have the being held and was starting food temperatures. The poserved below his chef's cap. The policy is observed to not be covered. The policy is observed to have being held hout the kitchen area. The			designee, will observe approp covering, dating, and labeling food items used for medication administration on a weekly bar for three months. Elements of non-compliance with this polic will be addressed promptly. § The community's Executive Director, or their designee, will complete random monthly aud for three months. Any deviation from compliance will be addrespromptly.	riate of n sis y l lits	

State Form Event ID: FJ1X11 Facility ID: 014079 If continuation sheet Page 6 of 10

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. B	MULTIPLE CO BUILDING VING	nstruction <u>00</u>	COM	TE SURVEY MPLETED 22/2023
	PROVIDER OR SUPPLIEI	R SISTED LIVING AND MEMORY (CARE	1255 DE	DDRESS, CITY, STATE, ZIP CO EMAREE ROAD WOOD, IN 46143	DD .	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION was observed to not be		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE
	Contractor 7's hair covered. - Contractor 8 was the kitchen area near the dish washi approximately 1 in approximately 3/4 and below the lips. observed to not be conserved wearing a her forehead, in from the first hat, approximately 3/4 was throughout the kitch the steamtable area to have braids approximately Aide 4 was throughout the kitch the steamtable area to have braids approximately Aide 5 was throughout the kitch steamtable area. Display Aide 5 was throughout the kitch steamtable area. Display Aide 5's bracovered. During an interview staff's hair, includir covered with either staff's hair, includir covered with either staff's hair "should indicated the facility either wear a hair near the dish was the kitch was a single first and the facility of the covered with either staff's hair "should indicated the facility either wear a hair near the staff's hair and the facility either wear a hair near the staff's hair and the staff's hair includir covered with either wear a hair near the staff's hair and the staff's hair an	was observed to not be observed walking throughout ar the steamtable and walking ng room. Contractor 8 had hair ch in length and had facial hair inch in length observed above Contractor 8's hair was covered. ved preparing the tomato and the noon meal. Cook 6 was a chef's hat. The hair across nt of the ears, and below the nately 2 inches in length, was					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER			UILDING	00	COMPL 08/22/	ETED	
	PROVIDER OR SUPPLIER	SISTED LIVING AND MEMORY CA	ARE	1255 DE	ADDRESS, CITY, STATE, ZIP COD EMAREE ROAD WOOD, IN 46143		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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
	covered. During an interview staff were to wear a 6 indicated it was "covered while wear 4. During a followu 8/21/23 from 1:15 p was observed: - Dietary Aide 2 was teamtable where the and was observed warea. Dietary Aide hair approximately hair was observed to - Cook 3 was at the foods were being he the ending food temporal approximately 3 incobserved below his observed to not be considered. - The DM was obsesteamtable where the and walking through DM was observed to not be considered.	at that time, Cook 6 indicated hair net or a chef's hat. Cook difficult" to keep all the hair ing a chef's hat. p kitchen observation on on.m. to 1:20 p.m. the following as standing next to the ne noon foods were being held valking throughout the kitchen 2 was observed to have facial half inch in length. The facial on not be covered. steamtable where the noon reld and was observed taking inperatures. Cook 3 had braids, when in length, that were chef's cap. The braids were covered. rved walking near the ne noon foods were being held shout the kitchen area. The					
	the kitchen area nea noon foods were be the dish washing ro- approximately 2 inc hair approximately	observed walking throughout at the steamtable where the ing held and was walking near om. Contractor 7 had hair thes in length and had facial 3/4 inch in length. Contractor and to not be covered.					

State Form Event ID: FJ1X11 Facility ID: 014079 If continuation sheet Page 8 of 10

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. B	MULTIPLE CO FUILDING VING	nstruction 00	COM	E SURVEY PLETED 2/2023
	PROVIDER OR SUPPLIEI	R BISTED LIVING AND MEMORY (CARE	1255 DE	DDRESS, CITY, STATE, ZIP CO EMAREE ROAD WOOD, IN 46143	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	RECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE
	the kitchen area near noon foods were he dish washing room approximately 1 in approximately 3/4 and below the lips. observed to not be a conserved to not be a conserved to not be a conserved wearing a her forehead, in from the first hat, approximately and the result of the conserved to not be a conserved to not be a conserved to have be a con	ved near the steamtable where being held and observed the kitchen area. Cook 6 was chef's hat. The hair across nt of the ears, and below the nately 2 inches in length, was					

State Form Event ID: FJ1X11 Facility ID: 014079 If continuation sheet Page 9 of 10

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CC	NSTRUCTION	(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION IDE	NTIFICATION NUMBER	A. BU	A. BUILDING 00 C			LETED	
			B. WI	NG	08/		22/2023	
			<u> </u>	CTREET	DDDEGG OFFI GTATE ZID COD			
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
	TE ODOCCINO ACCIO		יחר		EMAREE ROAD			
DEMARE	EE CRUSSING ASSIST	ED LIVING AND MEMORY CA	AKE	GREEN	IWOOD, IN 46143			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY N	MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE	3	COMPLETION	
TAG	REGULATORY OR LSC	DENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	and dating on all perish	able stock itemsall hair						
	must be restrainedall	beardsany hair below the						
	neck restrained according	ng to state/county						
	regulations for foodserv	vice"						
	On 8/22/23 at 2:30 p.m.	., a review of the Retail Food						
	Establishment Sanitatio	n Requirements Title 410						
	IAC 7-24, effective No	vember 13, 2004, indicated						
	" may not exceed a m	anufacturer's use by						
	daterefrigerated, read	y-to-eat, potentially						
	hazardous food prepare	d and held in a retail food						
	establishment for more	than twenty-four (24)						
	hours shall be clearly m	arked to indicate the date						
	or day by which the foc	od shall be consumed on						
	the premisesdiscarded	lfood shall be protected						
	from contamination by	storing the food as						
	follows:(5). In packa	ges, covered containers, or						
	wrappingswrap food t	tightly to prevent cross						
		nployees shall wear hair						
	restraints, such as hats,	hair coverings or						
	netsthat are designed	-						
	keep their hair from cor	ntactingexposed food"						
		- ^						

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