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	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STORYPOINT FORT WAYNE WEST	611 W COUNTY LINE RD SOUTH FORT WAYNE, IN 46814

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: June 21, 22 and 23, 2022 Facility number: 011804 Provider number: NA Aim number : NA Residential Census: 109 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed June 27, 2022	R 0000	Storypoint Fort Wayne West submits this response and Plan of Correction (POC) as part of the requirements under State and Federal law. This provider respectfully requests that the 2567 Plan of Correction be considered (POC) be considered the Letter of Credible Allegation and requests paper compliance in lieu of a Post Survey Review.	
R 0088 Bldg. 00	410 IAC 16.2-5-1.3(c)(1-2)(d)(1-2) Administration and Management - Noncompliance c) The licensee shall: (1) appoint an administrator with either a: (A) comprehensive care facility administrator license as required by IC 25-19-1-5(c); or (B) residential care facility administrator license as required by IC 25-19-1-5(d); and (2) delegate to that administrator the authority to organize and implement the day-to-day operations of the facility. (d) The licensee shall notify the director: (1) within three (3) working days of a vacancy in the administrator's position; and (2) of the name and license number of the replacement administrator Based on record review and interview, the facility failed to ensure the Executive Director (ED) obtained and maintained a current administrator's	R 0088	-What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	07/28/2022

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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	license in 1 of 1 review. Findings include: A review of employee records on 6/22/22 at 9:35 AM indicated the ED began employment at the facility on 6/14/21. There was no record of Administrator licensure available for review. The IN.gov PLA website, 2022, was utilized on 6/22/22 at 9:55 AM. No current Residential Care Administrator licensure found in regards to the current Administrator. The ED was interviewed on 6/22/22 at 10:15 AM. She indicated she had taken the Residential Care Administrator Licensure Exam and failed. She indicated she was waiting for a criminal check and other necessary paperwork to be completed before she could repeat the Residential Care Administrator Licensure Exam. Interviewed Company Consultant 3 on 6/22/22 at 11:37 AM. She reported that she works for the parent compnay of StoryPoint Fort Wayne West. She indicated visited the facility in Feb or March for 2 days to assist the ED. She further indicated she was available by phone 24/7 as a mentor. She indicated she and the facility commonicated approximately 3 times a week concerning 1) regulations, 2) company systems and 3) new programs. She indicated it was not typical for the company to hire non licensed administrators, however they were unable to find anyone else to fill the role.		**No residents were affected by the alleged deficient practice.** -How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; **The Community realizes that residents could have had the potential to be affected by the alleged deficient practice.** -What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; **Recruitment efforts will be on-going until an interim or a permanent Health Facility Administrator or Residential Care Administrator is appointed to the position of Executive Director of the Community. (Please see Exhibit A).** **Meanwhile, Consultant # 3 will continue to provide mentorship to the current Executive Director by on-site visits every other week and scheduled training calls three (3) times per week with a structured learning plan. Mentor #3 is available by phone 24/7.** -How the corrective action(s) will be monitored to ensure the deficient practice will not recur,	

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			i.e., what quality assurance program will be put into place; and **The licensee will notify the Director within three (3) working days of a vacancy in the Administrator's position. Recruitment efforts will begin immediately until a replacement or an interim is found. (Please see exhibit A.** -By what date the systemic changes will be completed. 7/28/2022	
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 record review and interview the facility failed to ensure criminal background and references checks completed for 3 of 5 employee records. (Activity aide 13, Cook 5, and LPN 14.) Findings include: A review of employee files was completed on 6/23/22 at 10:05 AM. Activity aide 13's criminal record and references screening could not be located. Cook 5's criminal record and reference	R 0116	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice **No residents were affected by the alleged deficient practice.** -How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;	07/28/2022

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	screening was not located. LPN 14's reference screening was not located. The Director of Nursing was interviewed on 6/23/22 at 12:28 PM. She indicated Activity aide 13's criminal record and references screening were unavailable for review. Cook 5's criminal record and reference screening were unavailable for review. LPN 14's reference screening was unavailable for review. The Administrator was interviewed on 6/23/22 at 1:04 PM. She indicated Activity aide 13's criminal record and references screening were unavailable for review. Cook 5's criminal record and reference screening were unavailable for review. LPN 14's reference screening was unavailable for review. On 6/23/22 at 1:04 pm the Administrator provided the SPGC Employee Hire checklist. The checklist indicated that background check was required. The Administrator indicated that she was not aware of any policy for maintaining employee records. No further documentation was provided by time of exit.		**The Community realizes that residents could have had the potential to be affected by the alleged deficient practice.** -What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The systemic change is that no one will be allowed to work in the Community until an criminal background check and reference checks have been received. (Please see Exhibit B). -How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. All employee records will be audited by 7/15/2022. Audits will be conducted at least quarterly thereafter. -By what date the systemic changes will be completed. 7/28/2022	
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3-Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following:			

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	(1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation.			
	Based on record review and interviews, the facility failed to ensure job specific orientation, facility orientation and dementia training were completed for 4 of 5 employee records reviewed. (Activity aide 13, Cook 5, LPN 14 and CNA15.) Findings include: A review of employee files on 6/23/22 at 10:05 AM. indicated Activity aide 13's facility orientation, job specific orientation, and dementia training was not located; Cook 5's facility	R 0119	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice **No residents were affected by the alleged deficient practice.** -How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; **The Community realizes that**	07/28/2022

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	orientation, job specific orientation, and dementia training was not located. LPN 14's facility orientation, job specific orientation, and dementia training was not located. CNA 15's facility orientation, and job specific orientation was not located. The Director of Nursing was interviewed on 6/23/22 at 12:28 PM. She indicated Activity aide 13's facility orientation, job specific orientation, and dementia training was unavailable for review. Cook 5's facility orientation, job specific orientation, and dementia training was unavailable for review. LPN 14's facility orientation, job specific orientation, and dementia training was unavailable for review. CNA 15's facility orientation, and job specific orientation was unavailable for review. The Administrator was interviewed on 6/23/22 at 1:04 PM. She indicated Activity aide13's facility orientation, job specific orientation, and dementia training was unavailable for review. Cook 5's facility orientation, job specific orientation, and dementia training was unavailable for review. LPN 14's facility orientation, job specific orientation, and dementia training was unavailable for review. CNA 15's facility orientation, and job specific orientation was unavailable for review. On 6/23/22 at 1:04 pm the Administrator provided the SPGC Employee Hire checklist. The checklist indicated orientation to the physical layout of the facility, and job specific orientation are required. The Administrator indicated that she was not aware of any policy for maintaining employee records. No further documentation was provided by time of exit.		**residents could have had the potential to be affected by the alleged deficient practice.** -What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The systemic change will be the re-implementation of the New Hire Orientation and Training to the hiring leaders. (Please see exhibit D). -How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The employee files will be audited by 7/15 to ensure no further discrepancies exist and correct any negative findings by use of an audit tool. (Please see Exhibit An audit will be completed quarterly thereafter. -By what date the systemic changes will be completed. 7/28/2022	

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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, 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 record review and interviews the facility	R 0120	What corrective action(s) will be	07/28/2022

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	failed to ensure resident rights training was completed for 3 of 5 employee records reviewed. (Activity aide 13, Cook 5, and LPN 14.) Findings include: A review of employee files was completed on 6/23/22 at 10:05 AM. Activity aide 13's resident rights training was not located. Cook 5's resident rights training was not located. LPN 14's resident rights training was not located. The Director of Nursing was interviewed on 6/23/22 at 12:28 PM. She indicated Activity aide 13's resident rights training was not available for review. Cook 5's resident rights training was not available for review. LPN 14's resident rights training was not available for review. The Administrator was interviewed on 6/23/22 at 1:04 PM. She indicated Activity aide 13's resident rights training was not available for review. Cook 5's resident rights training was not available for review. LPN 14's resident rights training was not available for review. No further documentation was provided by time of exit.		accomplished for those residents found to have been affected by the deficient practice **No residents were affected by the alleged deficient practice.** -How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; **The Community realizes that residents could have had the potential to be affected by the alleged deficient practice.** -What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur An in-service education regarding resident rights and any other issues identified as lacking will be conducted on 7/14/2022. The systemic change will be monthly audits of the Relias education system to determine compliance. Employees will be held accountable for non-compliance. -How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Monthly audits of the Relias education system. Any non-compliance will be brought to the attention of the employee's functional leader who will address the non-compliance. -By what date the systemic	

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		A. BUILDING 00 B. WING	06/23/2022

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			changes will be completed. 7/28/2022	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.			

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	(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interviews the facility failed to ensure health screenings and two step tuberculosis skin testing was completed in a timely manner for 2 of 5 employee records reviewed. (Activity aide 13 and Cook 5.) Findings include: A review of employee files was completed on 6/23/22 at 10:05 AM. Activity aide 13's health screening was not located. Cook 5's had a tuberculosis skin test dated 6/22/22. No records were available to indicate a follow up tuberculosis skin test had been performed within one to three weeks of the initial test. No chest film or annual tuberculosis risk assessment records were found The Director of Nursing was interviewed on 6/23/22 at 12:28 PM. She indicated Activity aide 13's health screening was not available for review. Cook 5's two-step tuberculosis skin testing, chest film or tuberculosis risk assessment records was not available for review. The Administrator was interviewed on 6/23/22 at 1:04 PM. She indicated Activity aide 13's health screening was not available for review. Cook 5's two-step tuberculosis skin testing, chest film or tuberculosis risk assessment records was not available for review.	R 0121	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice **No residents were affected by the alleged deficient practice.** -How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; **The Community realizes that residents could have had the potential to be affected by the alleged deficient practice.** -What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The hiring manager and Wellness Director will ensure will ensure that health screenings are completed before hiring. The Wellness Director will develop a system that generates reminders for 2nd step tuberculosis skin testing. -How the corrective action(s) will be monitored to ensure the deficient practice will not recur,	07/28/2022

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	On 6/23/22 at 1:04 pm the Administrator provided the SPGC Employee Hire checklist. The checklist indicated two-step skin testing/chest film is required. The Administrator indicated that she was not aware of any policy for maintaining employee records. No further documentation was provided by time of exit.		i.e., what quality assurance program will be put into place All new hires will be reviewed by the Property Administrator to ensure health screenings have been completed and will review new hires after thirty days of employment for the 2nd step TB test. -By what date the systemic changes will be completed. 7/28/2022	
R 0155 Bldg. 00	410 IAC 16.2-5-1.5(l) Sanitation and Safety Standards - Deficiency (l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items. Based on observation, interview and record review the facility failed to ensure garbage and refuse were contained in the dumpster, 4 industrial trash cans in the kitchen and 2 trash cans in the main dining room in 4 of 4 observations. Findings include: 1. An observation was made of the dumpster with Chef 2 on 6/22/22 at 7:55 AM. The gates and lids of the dumpster open were open. The area was littered with cigarette butts, mask, cardboard box, tire and other debris. She indicated maintenance takes care of the area.	R 0155	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice **No residents were affected by the alleged deficient practice.** -How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; **The Community realizes that residents could have had the potential to be affected by the alleged deficient practice.**	07/28/2022

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	An observation was made of the dumpster with Maintenance 7 on 6/22/22 at 8:51 AM. The gates and lids of the dumpster were open. The area was littered with cigarette butts, mask, cardboard box, tire and other debris. There was a sign that stated, "No Smoking" attached to the fence surrounding the dumpster. A cement planter was observed in the fenced area of the dumpster with cigarette butts in it. Maintenance 7 was interviewed on 6/22/22 at 8:51 AM. He indicated maintenance put up the no smoking sign, but employees continue to smoke there. He also indicated every Monday the dumpster area was cleaned by staff but did not appear to have been cleaned lately. He also indicated the lids were left open so the staff can throw their trash away. 2. An observation was made of three trash containers in the kitchen on 6/21/22 at 10:30 AM. There was trash in each container, but there were no lids on the trash containers. An observation was made of two trash containers in the main dining room on 6/22/22 at 8 AM. There was trash in each container, but there were no lids on the trash containers. An observation was made of two trash containers in the main dining room on 6/22/22 at 12:17 PM. There was trach in each container, but there were no lids on the trash containers. An observation was made of four trash containers in the kitchen on 6/23/22 at 8:45 AM. There was trash in each container, but there were no lids on the trash containers. The Chef 2 was interviewed on 6/21/22 at 10:30		-What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; All trash cans now have lids. A dumpster cleaning up schedule was developed. The maintenance Director/designee will clean up the dumpster area three (3) times weekly and as needed. -How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place The dumpster will be checked daily by a member of the leadership team by using a tool called 1440 walk which prompts the leader to check the dumpsters and ensure the lids are closed. -By what date the systemic changes will be completed. 7/28/2022	

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	06/23/2022

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	AM. Chef 2 indicated there were no lids for the containers, but the containers should have the lids on them. A policy was requested on dumpster maintenance and lids for trash cans in kitchen. The Chef provided two current housekeeping policies on 6/23/22 at 11:58 AM. Both housekeeping policies referenced removal of trash from residential apartments to the dumpster only. No further policies were received by the time of exit.			
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 maintain safe food temperatures and handling for 109 of 109 residents residing in the facility. Findings include: 1. In an observation on 6/21/22 at 10:15 AM, the salad station cooler contained unlabeled, undated food including an opened package of two boiled eggs, 2 opened ham packages, and opened multiple packages of cheese. An observation was made of a speed rack which contained two trays of uncovered cookies and a tray containing two uncovered berry pies on 6/21/22 at 10:20 AM Chef 2 was interviewed on 6/21/22 at 10:15 AM. Chef 2 indicated the cheese and ham on the salad station cooler had been opened that morning but the staff had not had a chance to label the items. She further indicated there were lids to all the	R 0272	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice **No residents were affected by the alleged deficient practice.** How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; **The Community realizes that residents could have had the potential to be affected by the alleged deficient practice.** -What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; An in-service education was conducted. The following areas were addressed but not limited to: (Please see Exhibit E)	07/28/2022

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	containers on the salad station cooler which were labeled and dated; but they could not be located. She indicated the cookies and berry pies were leftovers from the evening meal 6/20/22. The staff should have covered and put in cooler or disposed of the cookies and berry pies properly the previous evening. 2. In an observation on 6/22/22 at 8:22 AM, Server 12 was observed transporting a food tray uncovered from the kitchen down the hall to the dining room. At 8:23 AM., Server 13 was observed to transport a food tray uncovered down the hall to a resident. In an observation on 6/22/22 at 12:20 PM, the ADON was observed transporting a food tray uncovered down the hall to the dining room . Server 13 was interviewed on 6/22/22 at 8:23 AM. She indicated food should be covered when being transported from the kitchen to dining room. 3.Chef 2 was interviewed on 6/21/22 at 9:45 AM. Chef 2 indicated food temperature logs had not been recorded prior to 5/24/22. A review of food temperature logs was completed on 6/23/22 at 11:58 AM. The logs indicated no food temps prior to 5/24/22. No temperatures for the dates of 5/28/22, 6/2/22, 6/17/22 and 6/18/22 were able to be located. 4. Chef 2 was interviewed on 6/21/22 at 9:45 AM. Chef 2 indicated cooler/freezer temperature logs had not been recorded prior to 5/24/22. Requested copy of all cooler/freezer temperature logs for last twelve months from Chef 2 on 6/21/22		-How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place The Executive Chef will monitor all of the identified issues three (3) times weekly for the next thirty (30) days. -By what date the systemic changes will be completed. 7/28/2022	

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	at 9:45 AM. A review of the cooler/freezer temperature logs was completed on 6/23/22 at 11:58 AM. The logs indicated a start date of logging cooler/freezer temperatures of 5/24/22 with logs dated 5/28/22, 6/2/22 and June 17th through June 22nd unable to be located. 5. In an observation on 6/21/22 at 9:55 AM., a half full box of shelled eggs was observed in the walk-in cooler. The shelled eggs had no "P" stamped on their shell. Chef 2 indicated the eggs were unpasteurized Chef 2 indicated she used both liquid and pasteurized shelled eggs and the eggs in the box were pasteurized. Server 11 indicated five residents were served over easy or over medium eggs in the main dining room for breakfast on 6/22/22 at 8:33 AM. The ED (Executive Director) and Chef 2 were interviewed concerning unpasteurized eggs served at breakfast on 6/22/22 at 1:33 PM. The ED and Chef 2 indicated no unpasteurized eggs would be served and they would work on getting pasteurized eggs for their residents who wanted over soft and over medium eggs. A daily and weekly responsibility outline, dated 2/16/16, untitled, was provided by Chef 2 on 6/23/22 at 11:58 AM. The outline indicated the ...1) " P.M. cooks closing responsibilities included putting away all food items, consolidate food on speed rack, remove empty trays, cover, label, and date mark as needed." The outline further indicated the ...4) " P.M. cooks closing responsibilities included fill out refrigeration temperature log."			

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	A standard operating procedure, revised 2/17/22, titled "Suspected Foodborne Illness Outbreak," was provided by Chef 2 on 6/23/22 at 11:58 AM. The procedure indicated the cold storage procedure was ...1) " Keep foods properly wrapped or covered and dated with date opened and date expires." The procedure further indicated ..."All cooked or prepped foods need to be in containers that are covered, labeled, and dated with date made and date expires." The procedure also indicated ..."When to date mark foods: Anytime the original packaging is opened and anytime ingredients are combined to make something new. How to date mark foods: Apply masking tape or label to container, write what is in container, write today's date, draw an arrow, write a date six days from today." The procedure addressed refrigerator and freezer temperatures and indicated ...4) "Have thermometers in all refrigerators and freezers and check them daily to ensure proper temperatures are being kept." A standard operating procedure, revised 2/17/22, titled "Department Specific Procedures - Culinary Services," was provided by Chef 2 on 6/23/22 at 11:58 AM. The procedure indicated ...3) "Items below must be maintained at the Serv Safe recommended temperatures: All potentially hazardous food must be kept at 41 degrees Fahrenheit or less, or at less 135 degrees Fahrenheit or above, except during preparation, cooking, or cooling." The procedure further indicates ...4) "Thermometers must be placed in hot and cold storage areas in accordance with accepted public health standards." The procedure also indicated ...5) "Fresh eggs may be prepared only in the following manner: baked, hard-boiled, fried, scrambled. Pasteurized eggs may be served soft boiled."			

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	A standard operating procedure, revised 6/6/22, titled "Resident Room Trays," was provided by Chef 2 on 6/23/22 at 11:58 AM. The procedure indicated the purpose of the procedure ...2)"is to provide a temporary delivery and meal set up service for residents." The procedure further indicates ..."a covered ...tray and a covered beverage will be delivered." No further documentation was provided by the time of exit.			
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, record review and interview the facility failed to maintain the kitchen sanitation with hair coverings, personal items in food preparation areas, food preparation utensils, and equipment for 109 of 109 residnets residing in the facility. 1. In an observation on 6/21/22 at 9:46 AM., the Dining Room Manager was observed in the kitchen with out a hairnet covering her hair. Cook 6 was observed in the kitchen preparation area preparing bread sticks without a hairnet covering her hair. Chef 2 was interviewed on 6/21/22 at 10:00 AM. Chef 2 indicated Cook 6 must have lost her hairnet and returned with a hairnet for Cook 6. 2. On 6/21/22 at 10:00 AM., an observation was made of keys, open pop cans and styrofoam cups	R 0273	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice **No residents were affected by the alleged deficient practice.** How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; **The Community realizes that residents could have had the potential to be affected by the alleged deficient practice.** -What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; An in-service education was	07/28/2022

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	with straws sitting on the food prep table in the kitchen. Chef 2 relocated the keys and other items. Chef 2 informed Cook 6 her keys would be in her office. 3. On 6/21/22 at 10:08 AM, an insulated cart was observed sitting in the kitchen beside the steamer table. The cart had dirt dishes sitting on top. At 10:15 AM, an observation was made of a storage area under the microwave and sink. The storage area contained a used towel, and several clean towels. Chef 2 was interviewed 6/21/22 at 10:08 AM. Chef 2 indicated the cart was returned after breakfast from the Memory Care unit and contained dirty dishes. She indicated it should have been in the dishwasher area. Chef 2 indicated the storage area under the microwave and sink was for grill cleaning supplies storage and the clean towels should not be in the storage area. 4. An observation was made of the double stacked oven on 6/21/22 at 10:22 AM. The double stacked oven was black inside the oven walls and contained black flakes piled on the bottom of the upper oven. The windows of the upper and lower ovens could not be observed due to a dark tan film on the inside of the oven. Chef 2 was interviewed on 6/21/22 at 10:30 AM. Chef 2 indicated the double ovens were dirty and needed cleaning. Chef 2 reported back concerning double ovens on 6/21/22 at 11:55 AM. Chef 2 indicated the double ovens had not been cleaned in one year A standard operating procedure, revised 2/17/22, titled "Department Specific Procedures - Culinary		conducted. The following areas were addressed but not limited to: (Please see Exhibit E) -How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Executive Chef will monitor all of the identified issues three (3) times weekly for the next thirty (30) days. -By what date the systemic changes will be completed. 7/28/2022	

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	Services," was provided by Chef 2 on 6/23/22 at 11:58 AM. The procedure indicated ...1) "Food handlers must wear hairnets or caps to effectively keep hair from contacting exposed food, clean equipment, utensils and linens." The procedure further indicated ...2) " Employees may not eat or drink in the food preparation area." A standard operating procedure, revised 6/6/22, titled "Cleaning Log Schedule," was provided by Chef 2 on 6/23/22 at 11:58 AM. The procedure indicated ..."Cleaning Log Schedule is to ensure that our kitchens are maintaining a level of safety and sanitation in our audits." The procedure also indicates ..."The Cleaning Log is to be performed and checked daily during each shift." No policies were by the exit conference concerning proper storage of dishware, dirty/clean kitchen separation, and cleaning maintenance schedule of equipment.			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, record review and interview the facility failed to properly don and doff personal protective equipment (PPE) for 2 of	R 0407	What corrective action(s) will be accomplished for those residents found to have been affected by the	07/28/2022

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	3 residents observed (Resident 6, and Resident 11) Findings include: 1. The Director of Nursing (DON) was interviewed on 6/21/22 at 11:27 AM. The DON indicated Resident 6 and Resident 11 were on transmission based precautions due to testing positive for SARS-CoV-2 infection (COVID19). A continuous observation was made on 6/21/22 from 11:30 AM to 1:30 PM. At 12:31 AM, CNA 9 entered Resident 11's room with a gown, gloves, N95 mask and facesheld. CNA 9 exited the resident's room, took off her gown and gloves outside of the room and placed them in a trashcan. At 12 noon QMA 8 entered Resident 6's room with full PPE, this included a gown, gloves, N95 mask and face shield. At 12: 15 AM, QMA 8 exited Resident 6's room, took off her gown and gloves outside of the room and placed them in a trashcan. The DON was interviewed on 6/21/22 at 1 PM. The DON indicated staff should remove PPE prior to exiting the resident's room. 2. In a continuous observation on 6/21/22 from 9:37 AM to 11:55 AM, the following was observed: At 9:37 AM, Server 3 and Culinary Aide 4 were in the hallway by the private dining room on . They were observed not having their masks covering their nose. At 9:38 AM, Server 3 was observed walking in the corridor by the private dining room without her mask covering her nose At 9:47 AM, Cook 6 was observed with her mask was not covering her nose, and she would pull the mask down when talking to others.		deficient practice **No residents were affected by the alleged deficient practice.** -How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; **The Community realizes that residents could have had the potential to be affected by the alleged deficient practice.** -What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; An in-service education was conducted on all areas identified as well as handwashing. (Please see exhibit F) -How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place The Wellness Director/designee will visually observe all identified areas three (3) times weekly for the next thirty days to ensure compliance. -By what date the systemic changes will be completed. 7/28/2022	

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	At 10:00 AM, Cook 6 was observed with her mask around her neck not covering her mouth and nose. At 10:22 AM, Cook 5 was observed by steam table with their mask was not covering their nose. At 11:17 AM, Cook 6 was observed without her mask covering her nose. She was in the food prep area. At 11:45 AM, Cook 5 was observed in the kitchen with their mask around their neck region, not covering mouth or nose. They were by the steam table in the serving area. At 11:55 AM, Cook 5 was observed in the kitchen with their mask not covering their mouth or nose. They were by the steam table in the serving area. Observations on 6/22/22 included the following: At 7:45 AM, Cook 5 and Cook 6 were observed by the steam table with masks not covering their noses. At 11:15 AM, Cook 6 was observed in the food prep area preparing pureed food without a mask covering her nose. At 1:38 PM, Server 3 arrived in the kitchen with her mask below her nose. Observations on 6/23/22 included the following: At 9:00 AM, Cook 6 was observed in the food prep area preparing pureed food without a mask covering her nose. At 9:05 AM, Cook 6 was observed in the dishwashing area without a mask covering her nose. Server 3 and Culinary Aide 4 were interviewed on 6/21/22 at 9:37 AM. Culinary Aide 4 indicated masks should cover both their mouth and nose. Server 3 and Culinary Aide 4 then placed their masks on properly. Chef 2 was interviewed on 6/23/22 at 9:08 AM. She indicated for proper mask placement, masks			

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	should be placed over the nose and mouth. A policy, revised 2/9/2022, titled "Personal Protective Equipment (COVID-19)," indicated ... ..."Proper sequence for doffing (taking off) PPE when caring for Residents with confirmed or suspected COVID-19: 1. Remove gloves taking care not to contaminate hands. 2 The gown is removed next, removing the gown away from body in a manner to prevent contamination: a). dispose in water receptable. b). if reusable gown is used, once removed, place in soiled laundry container. 3. Perform hand hygiene upon exiting room. 4. Once employee is outside of the resident room, remove eye protection (face shield or goggles) being careful not to touch the front of the shield or goggles. Discard disposable eye protection." A policy, revised 2/9/2022, titled "Personal Protective Equipment (COVID-19)," indicated ..."Use facemasks according to product labeling and local, state and federal requirements." According to the Center of Disease Control and Prevention (CDC), 2022, a mask should "proper fit over your nose and mouth to prevent leaks." Types of masks and respirators. (2022, Jan. 28.) CDC. (https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/types-of-masks.html, 2022)			