PRINTED: 04/28/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
111,2 12,11	B. WING			04/13			
	PROVIDER OR SUPPLIER			297 S 10	DDRESS, CITY, STATE, ZIP CODE OO E NGTON, IN 47501		
(X4) ID PREFIX TAG R 0000	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PF	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
Bldg. 00	Survey. Survey dates: April Facility number: 00 Residential Census:	14904 28 al Finding is cited in	R 000	0			
R 0273 Bldg. 00	410 IAC 16.2-5-5. Food and Nutrition (f) All food prepara (excluding areas ir maintained in accollocal sanitation and standards, including Based on observation review, the facility food and prepared professional standard outside services were during 2 of 3 kitcher goods were stored of food storage observation Vendor) Finding includes: 1. During a kitcher 9:45 A.M., KS 3 (K.	and Services - Deficiency ation and serving areas a residents ' units) are ordance with state and d safe food handling and 410 IAC 7-24. an, interview, and record failed to ensure food was	R 027	3	="" p=""> Submission of this response a Plan of Correction is NOT a le admission that a deficiency ex or, that this Statement of	gal	05/14/2021

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

State Form Event ID: JKXO11 Facility ID: 004904 If continuation sheet Page 1 of 3

PRINTED: 04/28/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED		
		B. W	B. WING			04/13/2021	
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE		
				297 S 1			
EMERAL	.D PLACE			WASHI	NGTON, IN 47501		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	DROWIDER'S DLAN OF CORRECTION		(X5)
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'	T.E.	COMPLETION
TAG				TAG DEFICIENCY)			DATE
	mushrooms in preparation for lunch, without a				Deficiencies was correctly cite	correctly cited,	
	hair cover or hair net.				and is also NOT to be constru		
	1.00				as an admission against intere	inst interest	
	At 9:50 A.M., AE 1	(Administrative Employee)			by the residence, or any		
		and walked to the sink to			employees, agents, or other		
	drop off dishes with	hout wearing a hair cover or		individuals who drafted or ma		/ be	
	hair net.	C		discussed in the response or l		Plan	
				of Correction. In addition,			
	During a kitchen observation on 4/12/21 at				preparation and submission of		
	11:25 A.M., an outside food vendor was walking				Plan of Correction does NOT		
	through the kitchen	during meal service not			constitute an admission or		
	wearing a hair cover or hair net.				agreement of any kind by the		
					facility of the truth of any facts		
	During an interviev	v on 4/12/21 at 10:00 A.M.,			alleged or the correctness of a	iny	
	KS 3 indicated staf	f should cover their hair while			conclusions set forth in this		
	in the kitchen.				allegation by the survey agency.		
					1. Kitchen Staff 3 and		
	On 4/13/21 at 12:49 P.M., the Administrator				Administrative Executive 1 we	re in	
	supplied an undated facility policy titled, Dining				serviced on 4/13/2021 by		
	Room Etiquette and	d Dress Code. The policy			Executive Director (ED) regarding		
	included, "Hair nets	s, chef hats, or skull caps that			proper hair net usage. Canned		
	cover all hair must be worn in the food				goods were removed from floor		
	preparation area in the kitchen."				and stored appropriately on		
					4/13/2021 by Kitchen Staff#3.		
	2. During a food storage observation on 4/12/21 at 9:45 A.M., a flat of canned tomato juice was				(Attachment #1)		
					2. An audit was conducted on		
	being stored on the floor of the dry food storage			4/21/2021 by ED of staff to			
	room.				ensure they are wearing		
					appropriate hair coverings whi		
	_	ige observation on 4/13/21 at			the kitchen and were re-educa		
		of canned tomato juice was			at time of findings. (Attachmer		
	being stored on the	floor of the dry food storage			#2) An audit was conducted o		
	room.				4/21/2021 by ED of food stora	-	
					areas to ensure canned goods		
	_	v on 4/13/21 at 10:50 A.M.,			were stored appropriately with	no	
		knowing the canned tomato			additional findings noted		
		food should not be stored on			(Attachment #3).		
	the floor.				3. Current staff will be in service	ced	
					by 4/29/2021 on all storage,		
	On 4/13/21 at 12:49	9 P.M., the Administrator			preparation and professional		

State Form Event ID: JKXO11 Facility ID: 004904 If continuation sheet Page 2 of 3

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

PRINTED: 04/28/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED				
		B. WING		04/13/2021				
		CTDEE	TADDRESS CITY STATE ZID CODE					
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
EMEDAL	D PLACE		297 S 100 E WASHINGTON, IN 47501					
EIVIERAL	D FLACE	WAS	HINGTON, IN 47501					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)				
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE	COMPLETION				
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	DEFICIENCY)	DATE				
	supplied a facility policy titled, Storage of		standards of food storage ar					
	Products, dated, 4/17/2017. The policy included,		policy and procedure on Din	•				
	"Items should be placed behind similar items		Room Etiquette and dress co	•				
	already on the shelf."		which includes staff and outs					
			services use of hairnets whil					
			kitchen by ED. A reminder s	gn				
			indicating a hair covering is					
			required was placed at kitch	en				
			door on 4/21/2021 by ED					
			(Attachment #4)					
			4. The Dietary manager is					
			responsible for sustained					
			compliance. The Executive					
			Director and/or designee will					
			monitor for proper use of hai					
			coverings while in the kitche					
			proper food storage 5x / wee	ek for				
			4 weeks, then 3x/week for 4					
			weeks and 1x/week for 4 we	eks.				
			Results of the audit will be	41				
			discussed at monthly QI and committee will determine if	uie				
				on				
			auditing is necessary based three consecutive months of					
			compliance. Monitoring will be					
			-) C				
			ongoing. 5. May 14th, 2021					
			J. May 1401, 2021					

State Form Event ID: JKXO11 Facility ID: 004904 If continuation sheet Page 3 of 3