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	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COUNTRY CHARM	3177 MERIDIAN PARKE DR GREENWOOD, IN 46142

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: September 11, 12, and 13, 2023 Facility number: 011478 Residential Census: 83 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed September 15, 2023.	R 0000	This Plan of Correction is submitted as required under State law. The submission of this Plan of Correction does not constitute an admission on the part of Country Charm as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. The submission of this Plan of Correction 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 judicial and/or administrative proceeding on that basis. The Community also 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
Julie Madison	Executive Director	09/29/2023

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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			· What corrective action(s) will be accomplished for those residents found to have been affected by the 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; · What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; · 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 · By the date the systemic changes will be completed.	
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			

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	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 potentially hazardous materials were kept secure behind locked doors to prevent resident access for 3 of 3 days of the survey. (Maintenance Shop, Storage Room) Findings include: 1. On 9/11/23 from 9:55 a.m. to 10:00 a.m., during a facility tour with the Wellness Director, the Maintenance Shop, located next to the two resident apartments and near the community chapel, was observed. The Maintenance Shop's door was observed to be open and inside the room, included but were not limited to, multiple tools, wires, construction material, light bulbs, batteries, nails, screws, and a 16-ounce can of of Terro Ant Killer spray. The warning label on the Terro Ant Killer spray indicated "...Caution...harmful if swallowed." No staff were visible in the area during that time. During an interview at that time, the Wellness Director indicated the Maintenance Shop's door was to be kept closed and locked. During an interview on 9/11/23 at 2:15 p.m., the Maintenance Director indicated that the Maintenance Shop's door was to be kept closed and locked when staff were not present. 2. On 9/11/23 from 10:05 a.m. to 10:10 a.m., the storage room, located next to the laundry room and the janitor room and near Rooms 222 and 224, was observed. The storage room door was	R 0148	1 The Maintenance Shop's door and the storage room, located next to the laundry room and the janitor room and near Rooms 222 and 224 are locked to prevent residents from having access to potentially hazardous chemicals. 2 The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3 All maintenance and care staff were in-serviced on 09/21/23 to ensure they were aware of the importance of locking all storage and maintenance doors to prevent residents from accessing harmful chemicals or other hazardous conditions. 4 The Maintenance Director or designee will conduct an audit of all storage and maintenance doors to ensure all are locked. Said audit will occur weekly for four weeks and monthly for an additional three months. 5 Corrective date: September 30, 2023	09/30/2023

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	unlocked. Inside the room were multiple packages of incontinent supplies, boxes of plastic gloves, boxes of facial masks, and bottles of hand sanitizers. The label on the hand sanitizers indicated, "keep out of reach...for external use only...in case of accidental ingestion-contact physician or poison control right away..." The wall opposite the entry door was observed to have multiple wires and cables attached to the metal box. No staff were visible in the area at that time. During an interview at that time, the Wellness Director indicated the storage room door was to be kept locked. On 9/12/23 from 11:00 a.m. to 11:05 a.m., the same storage room was observed. The door was unlocked and inside the room, the same was observed. No staff were visible in the area at the time. On 9/13/23 from 10:05 a.m. to 10:10 a.m., the same storage room was observed. The door was unlocked and inside the room, the same was observed. No staff were visible in the area at the time. During an interview on 9/13/23 at 9:00 a.m., the Wellness Director indicated there were 3 cognitively impaired self-mobile residents residing in the facility who could have had access to the unlocked Maintenance Shop and storage room. On 9/12/23 at 9:36 a.m., the Administrator provided a copy of the Storage and Disposal of Hazardous Materials policy, dated August 2023, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...hazardous chemicals must never be left in			

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	locations which are accessible to Residents or visitors...must always be stored in a locking room..."			
R 0187 Bldg. 00	410 IAC 16.2-5-1.6(k) Physical Plant Standards - Deficiency (k) Hot water temperature for all bathing and hand washing facilities shall be controlled by an automatic control valve. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit. Based on observation, interview, and record review, the facility failed to ensure water temperatures were maintained between 100 degrees Fahrenheit and 120 degrees Fahrenheit for 2 of 9 resident rooms on the 400 unit. (Resident 86, Resident 79) Finding includes: 1. During a facility tour with the Maintenance Director on 9/13/23 at 10:40 a.m., Resident 86's apartment water temperatures were observed. The kitchen sink's hot water temperatures ranged between 125 degrees Fahrenheit (F) and 127 degrees F. During an interview at that time, Resident 86 indicated the hot water "gets really hot at times." On 9/13/23 at 11:50 a.m., Resident 86's clinical record was reviewed. The St. Louis University Mental Status (SLUMS, a cognitive mental status exam), dated 11/24/2020, indicated Resident 86 was cognitively intact. 2. During a facility tour with the Maintenance	R 0187	1 Resident 86 and 79 water temperatures were checked and were both were maintained between 100 degrees Fahrenheit and 120 degrees Fahrenheit after recalibration of the water heater on 9/13/23. 2 The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3 The Community checked water temperatures in all resident apartments to ensure all resident's water temperatures water temperatures were maintained between 100 degrees Fahrenheit and 120 degrees Fahrenheit. On September 21, 2023, the Administrator in-serviced the maintenance staff on water temperature safety. 4 The Maintenance Director	09/30/2023

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	Director on 9/13/23 at 10:50 a.m., Resident 79's apartment water temperatures were observed. The kitchen sink's hot water temperature was 129 degrees F and the bathroom sink temperature was 128 degrees F. During an interview at that time, Resident 79 indicated the hot water was "always very hot and it had been like that for awhile." On 9/13/23 at 12:01 p.m., Resident 79's clinical record was reviewed. The SLUMS exam, dated 1/24/2019, indicated Resident 79 was mildly cognitively impaired. On 9/13/23 at 11:55 a.m., the Maintenance Director provided a copy of the "Logbook Report: water temperature checks: test and log the hot water temperatures" for the previous 12 months. A review of the document indicated daily hot water temperatures were recorded for the 100 hall; 200 hall; 300 hall; 400 hall; and the kitchen. The report lacked any specific resident apartment recorded temperatures having been taken or recorded. At that time, the Maintenance Director indicated no hot water temperatures had been taken from any resident apartments. Hot water temperatures were monitored from the laundry room sinks on each unit. The Maintenance Director indicated "sometimes" the water would have to run for "a while to get the hot water down to an acceptable hot water temperature range for the 400 building unit." The hot water temperatures were to be monitored and maintained between 100 degrees F and 120 degrees F. During an interview on 9/13/23 at 12:02 p.m., the Administrator indicated the hot water temperatures were to be monitored and was to include a random selection of Resident apartments		or designee will check and log the water temperature in six randomly selected resident apartments to ensure the temperature is in the correct range. Said checks will occur weekly for four weeks and monthly for an additional three months. 5 Corrective date: September 30, 2023	

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	to ensure the appropriate water temperatures were maintained. On 9/13/23 at 12:05 p.m., the Maintenance Director provided an undated copy of the "Instructions: Water Temperature Checks: Test and log the hot water temperature" document and indicated it was the current process in place to monitor the hot water temperatures. A review of the document indicated, "...test the water at various locations throughout the facility...for burn prevention, federal guidelines advise that you keep domestic water temperatures below 120 degrees Fahrenheit...check resident rooms...record results in the water temperature log..." On 9/13/23 at 12:10 p.m., the Administrator provided an undated copy of the Sonida Water Temperature Policy and indicated it was the current policy in use by the facility. A review of the policy indicated, "...test the water at various locations throughout your facility...for burn prevention, federal guidelines advise that you keep domestic water temperatures below 120 degrees Fahrenheit...check resident rooms...record result in the temperature log..."			
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 dietary staff's hair was covered to prevent exposure to food while in the kitchen for 4 of 4 observations. (Dining Service Chef 2)	R 0273	1 All food service staff will wear hairnets in the kitchen area. 2 The Community reviewed each resident's record to determine which residents, if any,	09/30/2023

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	Findings include: On 9/11/23 from 9:20 a.m. to 10:00 a.m., observed Dining Service Chef 2 in the kitchen food preparation area where food was being prepared for the noon meal. Dining Service Chef 2 was observed to have multiple hairs, approximately 1/2 inches in length, near the neckline that were observed to not be covered as well as facial hair approximately 1/8 inches in length from cheek to ears exposed. On 9/11/23 from 11:20 a.m. to 12:45 p.m., observed Dining Service Chef 2 walking throughout the kitchen where the noon meal was being prepared by the Dining Service Chef 2. He was observed to cook, cover, and place the food in pans for steam table to be served to residents for noon meal. During preparation of foods the Dining Service Chef 2 was observed to have multiple hairs uncovered, exposing hair approximately 1/2 inches in length, near the neckline as well as facial hair approximately 1/8 inches in length from cheek to ears exposed. On 9/12/23 from 8:35 a.m. to 8:40 a.m., observed Dining Service Chef 2 at the preparation table in the kitchen, with a cloth wiping the prep table off where food was in place. Dining Service Chef 2 had multiple hairs, approximately 1/2 inches in length near the neckline were observed to not be covered as well as facial hair from cheeks to ears approximately 1/8 inches in length uncovered. On 9/11/23 at 9:25 a.m., observed a posted sign on the kitchen entry door. The posted sign indicated "Hair nets are required beyond this point." During an interview on 9/11/23 at 12:00 p.m., the		could be affected by the alleged deficient practice. 3 All Food Service staff were in-serviced on the importance of hairnets and beard nets to ensure all hair is in hairnets and beard nets to prevent exposure to food while in the kitchen on September 25. In addition, a mirror has been installed to ensure all staff can verify they have all hair in their hairnets. 4 The Executive Director or designee will conduct random inspections to ensure dietary staff's hair is covered to prevent exposure to food while in the kitchen. Said inspections will occur weekly for four weeks and monthly for an additional three months. 5 Corrective date: September 30, 2023	

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	Dining Service Chef 2 indicated that he was aware of sign on kitchen entry door indicated, "Hair nets are required beyond this point." During an interview on 9/13/23 at 8:25 a.m., the Executive Director indicated all kitchen staff should have been wearing hair nets. On 9/13/23 at 8:52 a.m., the Executive Director provided an undated copy of the Country Charm Dietary Dress Code which addressed hairnets, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...Hairnets Caps must be worn at all times in the kitchen..." On 9/12/23 at 3:00 p.m., a review of the Indiana Food Establishment Sanitation Requirements, Title 410 IAC 7-24, effective November 13, 2004, indicated, "...(b) food employees shall wear hair restraints, such as hats, hair coverings or nets...that are designed and worn to effectively keep their hair from contacting...exposed food..."			