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	04/19/2023

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KESSLERWOOD PLACE	5011 KESSLER BLVD E INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00403549. Complaint IN00403549 - No deficiencies related to the allegations are cited. Survey dates: April 17, 18, and 19, 2023 Facility number: 010064 Residential Census: 30 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 21, 2023	R 0000	*Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.*	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashley Lay-Wolf	RN, RDCS	05/02/2023

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	conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure fire drills were conducted monthly for 7 of 12 months reviewed. This had the potential to affect all 30 residents that reside at the facility. Findings include: The fire drills were provided by the Administrator on 4/18/23 at 11:25 a.m. The following fire drills were conducted: 4/29/22 on 3rd shift, 5/24/22 on 1st shift, 8/25/22 on 1st shift, 9/21/22 on 3rd shift, & 10/31/22 on 2nd shift. An "IN-SERVICE TRAINING SUMMARY", dated 3/14/23, indicated fire drills and fire evacuation were discussed with all staff. A document titled "Annual Training Calendar and Guidelines for Life Safety Drills", undated, was provided by the Administrator on 4/18/23 at 2:28 p.m. The document indicated a fire drill listed to be conducted monthly.	R 0092	R 092 Administration and Management - Noncompliance **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Executive Director (ED) or designee will conduct a fire drill on or before 5/5/2023. Any concerns identified will be corrected at that time. **2. 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?** An audit of 2022 and 2023 fire drill	05/02/2023

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			logs was completed on 4/20/2023 by ED with no additional fire drills omitted. **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur?** The ED was re-trained by Regional Director of Clinical Services (RDCS) on 4/20/2023 regarding fire drill regulation requirement (Attachment 1). New maintenance technician (MT) will be trained by the ED on the fire drill regulation requirement upon hire . Until a MT is hired and trained, ED will be responsible for ensuring regulation is met. **4. 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 ED is responsible for sustained compliance. The ED or designee will audit the fire drill log monthly for 3 months, then	

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			bi-monthly for 2 months to ensure fire drills are completed per regulatory requirement. The audits will be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going. !--[if !supportAnnotations]-->	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties			

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	shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure a staff member with cardiopulmonary resuscitation (CPR) and first aid certification was on site during all shifts for 2 of 8 days for CPR and 3 of 8 days for first aid. This had the potential to affect all 30 residents that reside at the facility. Findings include: The schedules were reviewed from 4/11/23 to 4/18/23. The facility staff were identified per the binder with certifications for first aid and CPR. The following date(s) noted a lack of staff certified in CPR and/or first aid: 4/18/23- no first aid certified staff on day shift, 4/17/23- no first aid certified staff on night shift, 4/14/23- no first aid certified staff on night shift, 4/12/23- no CPR certified staff on night shift, & 4/11/23- no CPR certified staff on night shift. An interview conducted with the Regional Director of Clinical Services, on 4/19/23 at 4:36 p.m., indicated there wasn't first aid/CPR certified staff on each shift upon the schedules reviewed.	R 0117	R 117 Personnel – Deficiency **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On or before 5/5/2023, the ED and Care Services Manager (CSM) will review and update staffing schedule to ensure a minimum of one employee with current CPR and first aid certification will be present on each shift. **2. 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?** An audit of employee first aid/CPR certification was completed on 5/2/2023 by the ED. Employees without current first aid/CPR certification will obtain certification by 5/20/2023. **1.What measure will be put into place or what systemic**	05/15/2023

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			changes the facility will make to ensure that the deficient practice does not reoccur? The ED was re-trained by RDCS on 4/20/2023 to ensure a staff member with cardiopulmonary resuscitation (CPR) and first aid certification is on site during all shifts per the regulatory requirement (Attachment 1). **1.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 ED is responsible for sustained compliance. The Care Services Manager (CSM) or designee will audit the staffing schedule weekly for 4 weeks, biweekly for 4 weeks, then monthly for one month to ensure a first aid/CPR certified employee is always on site. The audits will be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on going.	

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R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to ensure a resident was assisted per his level of care and service plan for frequent checks to where a resident was later found without a pulse and/or respirations for an unknown period for 1 of 3 closed records reviewed. (Resident R32) Findings include: The clinical record for Resident R32 was reviewed on 4/19/23 at 3:00 p.m. The diagnoses included, but were not limited to, atrial fibrillation, depression, hypertension, Parkinson's disease, insomnia, and muscle weakness. Resident R32 was admitted to the facility on 2/25/23. A document titled "Indiana Physician Orders for Scope of Treatment (POST)", signed 3/8/23, by the physician regarding Resident R32 being a full code and to attempt resuscitation. A "Service Plan Summary", dated 2/25/23, indicated Resident R32 needed assistance with one staff for bathroom assistance, dressing and grooming, bathing, and transfers. Resident R32 was a high fall risk, forgetful to date, and required "frequent checks". A resident service note, dated 3/25/23 at 8:10 a.m., indicated the following, "...QMA [qualified medication aide] came to this writer and informed me that resident was on floor in his room. Upon entering resident's room resident was on floor next to bed face down unresponsive to verbal [symbol	R 0240	R 240 Health Services – Deficiency **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident R32 was found deceased on 3/25/2023. **2. 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?** CSM completed an audit of all service plans for residents that require frequent checks on 4/29/2023. CSM completed an audit of resident task sheets to ensure residents who require frequent checks are identified on the task sheet on 4/29/2023. All findings from these audits were corrected immediately.	05/15/2023

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	for and] tactile stimulation, 0 [no] pulse, 0 [no] respirations noted. Attempted to turn resident over to initiate CPR [cardiopulmonary resuscitation], when this writer noted resident's neck was laying against leg of table and did not move resident...8:35 a.m....Per EMS [emergency medical services] death pronounced [symbol for at] 8:32...." A resident service note, dated 3/25/23 at 11:40 a.m., indicated Resident R32's body was released to coroner's office at that time. An investigation statement, 3/25/23, from Resident Care Personnel (RCP) 9 indicated she checked on Resident R32 on 3/25/23 at 2:30 a.m., 3/25/23 at 4:30 p.m., and 3/25/23 at 6:00 a.m. while she conducted a final walk through with day shift RCP 10. An investigation statement, dated 3/25/23, from RCP 10 indicated the following, "...[Room number of Resident R32] likes to sleep in so I go to him last...He was face down and his head was laying under the TV [television] tray next to the bed. I touched him and he was cold so I called for the QMA [qualified medication aide]...He [Resident R32] is a 1 assist with all ADLs [activities of daily living]...." There was no indication that RCP 10 went into Resident R32's room prior to 8:00 a.m. An interview conducted with the Regional Director of Clinical Services (RDCS), on 4/19/23 at 3:48 p.m., indicated the RCP 9 commented on how she went into Resident R32's room at 6:00 a.m. to check on him but that didn't align with the timeline due to the extent of Resident R32 being deceased. Resident R32 was rigid and seemed like a while from what the night shift nurse told us. The last documented time someone was in there was the		**1.What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur?** The CSM was re-trained by RDCS on 4/20/2023 to ensure residents are assisted per their level of care and service plan for frequent checks; also ensure resident's needs are appropriately outlined on the task sheet (Attachment 2). CSM re-trained all clinical staff on 4/20/2023 to ensure residents are assisted per their level of care and service plan for frequent checks (Attachment 3). **1.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 CSM is responsible for sustained compliance. The CSM or designee will audit 5 resident services plans and task sheets weekly for 4 weeks, bi-weekly for	

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	night shift nurse on 3/25/23 at 3:45 a.m. for a temperature check. An interview conducted with RDCS, on 4/19/23 at 4:18 p.m., indicated since Resident R32 was an assist with one staff for toileting he would need to have been checked every "couple of hours". The expectations are for the RCPs to check on the residents every "couple of hours" depending on the level of assistance. She could believe that RCP 9 went into Resident R32's room at 4:00 a.m. but she confirmed with the day shift RCP, (RCP 10), that they didn't conduct a walk through nor go into Resident R32's room at 6:00 a.m.		2 months, then monthly for 1 month to ensure residents are assisted per their level of care and service plan for frequent checks. The audits will be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going. !--[if !supportAnnotations]-->	
R 0272 Bldg. 00	410 IAC 16.2-5-5.1(e) Food and Nutritional Services - Deficiency (e) All food shall be served at a safe and appropriate temperature. Based on observation, interview, and record review, the facility failed to ensure cold food were served at an appropriate temperature for 17 residents that receive food from Servery 1 and failed to ensure food temperatures were obtained prior to serving food for 13 residents that receive food from Servery 2. This had the potential to affect all 30 residents that reside in the facility. Findings include: An observation conducted with Chef 2, on 4/18/23 at 12:10 p.m., of food temperatures for Servery 1. The side salad temperature was obtained at 52 degrees. Chef 2 commented "that seems warm" but proceeded to serve the meal including the salad to the residents on the first-floor dining room. An observation conducted of Servery 2 on the	R 0272	R 272 Food and Nutritional Services – Deficiency **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Dietary Manager (DM) was re-trained by ED and RDCS on 5/2/2023 to ensure all food is served at an appropriate temperature at point of service (Attachment 4). **2. How will the facility**	05/15/2023

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	third floor, on 4/18/23 at 12:25 p.m., of Resident Care Personnel (RCP) 3 proceeding to prepare and pass food plates out to the residents on the 3rd floor. RCP 3 indicated there were no logs for food temperatures. An observation conducted of Servery 2 on the third floor conducted on 4/19/23 at 11:56 a.m. Dietary Assistant 4 proceeded to place a cart containing food for residents on the third floor. Licensed Practical Nurse (LPN) 5 and RCP 6 proceeded to start placing food on plates without conducting food temperatures prior to meal service. There were 12 residents sitting in the dining room on the third floor. A document titled "Four Factors that Directly Cause Food to Become Unsafe", undated, was provided by the Administrator on 4/18/23 at 2:28 p.m. The document indicated the following, "...Time and Temperature...Bacteria can grow in food whenever it remains in the "temperature danger zone", which is between 41 F [Fahrenheit] and 135 F for too long...." A document titled "Dining, Nutrition and Hospitality Process Procedure Review", dated 8/1/2020, was provided by the Administrator on 4/18/23 at 2:28 p.m. The document indicated the following, "...Meal Service...Hot food served hot, cold food served cold...Food Preparation...Daily Food Production - Substitution - Temperature log is completed...."		**identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** An audit of food temperature logs in the kitchen and serveries was completed on 5/2/2023 by the ED. Findings concluded that food temperatures were regularly checked in the kitchen but not in the serveries. **1.What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur?** The ED was re-trained by RDCS on 4/20/2023 to ensure cold food was served at an appropriate temperature (Attachment 1). The DM was re-trained on 5/2/2023 by ED and RDCS to ensure cold food was served at an appropriate temperature at point of service (Attachment 4). **1.How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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			recur, i.e., what quality assurance program will be put into place? The ED is responsible for sustained compliance. The DM or designee will audit temperature logs from serveries and the main kitchen weekly for 4 weeks, bi-weekly for 2 months, then monthly for 1 month to ensure food temperatures are completed routinely before serving. The audits will be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going. !--[if !supportAnnotations]-->	
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 adequate food storage regarding undated and expired food in the main kitchen, undated and expired food in the third-floor refrigerator, ensure functionality of dishwasher, the use of hairnets, and ensure a thermometer in the refrigerator and freezer located	R 0273	R 273 Food and Nutritional Services – Deficiency **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	05/15/2023

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	on the third floor. This had the potential to affect all 30 residents that reside in the facility. Findings include: 1. The main kitchen was observed on 4/17/23 at 12:20 p.m. The main refrigerator was observed with the following: - A head of lettuce in a bag that was brown in color with liquid in the bag, - A box of lemons, dated 3/16/23, that had brown spots, - A box of pastries with no date that were covered with clear wrap, - A container of salsa dated 9/16/22, - A container of Caesar Salad dressing with a best by date of 1/12/23, A holding fridge had a container of vegetable base with a best by date of 11/19/22. An interview conducted with Dietary Assistant 4, on 4/17/23 at 12:35 p.m., indicated she would go the kitchen and throw away the items listed above. 2. The first floor Servery (Servery 1) was observed with a dish machine on 4/18/23 at 12:10 p.m. The dish machine had a sticker that indicated it was a chemical dishwasher with a recommended temperature of 120 degrees for wash and rinse cycle along with 50 ppm (parts per million) on the sanitation at a minimum. The temperature was reading 108 degrees and went up to 113 degrees after another cycle. An observation conducted on 4/18/23 at 1:30 p.m. of Servery 1 indicated the dish machine was on and in the process of cleaning dishes. The		The lettuce, lemons, pastries, salsa, Caesar salad dressing, and vegetable base were discarded on 4/17/2023 by Dietary Assistant 4. Ecolab was called to service the dish machines on the first floor and third floor due low temperature on 5/2/2023. RCP 3, RCP 8, and Director of Memory Care were retrained by the CSM on 4/20/2023 on the kitchen and servery dress code, including wearing hairnets in the kitchen and servery (Attachment 3). **2. 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?** An audit of kitchen was done on 4/30/2023 by the CSM to ensure no outdated food present. Issues identified during this audit were addressed at that time and any outdated or unlabeled food was discarded at that time. **1.What measure will be put**	

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	temperature was noted at 107 degrees. There were no logs located in Servery 1 for the dish machine. 3. The third floor Servery (Servery 2) was observed on 4/18/23 at 12:25 p.m. Resident Care Personnel (RCP) 3, RCP 8, and the Director of Memory Care were present and preparing the cooked food onto plates. All three of them were not wearing a hairnet. The Director of Nursing (DON) came shortly after and directed the three staff members to obtain a hairnet while serving food. RCP 3 obtained a hairnet, but RCP 8 and the Director of Memory Care proceeded to prepare food without the use of a hairnet. There was a dish machine located in Servery 2. The dish machine had a sticker that indicated it was a chemical dishwasher with a recommended temperature of 120 degrees for wash and rinse cycle along with 50 ppm (parts per million) on the sanitation at a minimum. The dish machine was reading "Lo" on the gauge regarding temperature. An interview conducted with RCP 3, on 4/18/23 at 12:19 p.m., indicated "we don't take temperatures or have a log" when asked about the dish machine. The dish machine was run through a couple of cycles with the following temperature(s) noted: - First cycle at 102 degrees after rinse, - Second cycle at 108 degrees after rinse, & - Third cycle at 112 degrees after rinse. The refrigerator/freezer combo was observed in Servery 2 with 2 containers of what appeared to be orange juice with no date or label. There was a container of watermelon chunks with a sell by		**into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur?** The ED was re-trained by RDCS on 4/20/2023 to ensure adequate food storage regarding undated and expired food in the main kitchen and serveries, to ensure functionality of the dishwasher, the use of hairnets, and to ensure a thermometer is in all refrigerators and freezers (Attachment 1). The DM was re-trained by the ED and RDCS on 5/2/2023 to ensure adequate food storage regarding undated and expired food in the main kitchen and serveries, to ensure functionality of the dishwasher, the use of hairnets, and to ensure a thermometer is in all refrigerators and freezers (Attachment 4). **1.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 ED is responsible for sustained compliance. The ED or	

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	date of 4/10/23. There wasn't a thermometer in the refrigerator or freezer. There were 3 containers of what appeared to be lemonade noted on the counter being served to residents on the Memory Care Unit with no label or date noted. There was no temperature logbook located in Servery 2 regarding the dish machine and/or the refrigerator/freezer. A document titled "FOOD STORAGE GUIDELINES", undated, was provided by the Administrator on 4/18/23 at 11:25 a.m. The document indicated the following, "...1. Dating & Labeling...All food items must be labeled using food storage labels...Delivered food items must be labeled and received date...Prepared food items must be labeled with common name, prepared date and use by date...Guidelines to hold food...3 days - from preparation for prepared foods...7 days - from opening canned items like pudding, fruits, and vegetables...30 days - opened condiments like mayonnaise, ketchup, mustard, pickled foods, salad dressings, tomato products...." A document titled "Kitchen Appliance Temperature Logs", undated, was provided by the Administrator on 4/18/23 at 2:28 p.m. The document indicated the following, "...Appliance temperatures must be monitored daily and recorded on the Kitchen Appliance Temperature Log. Each appliance should have an internal appliance thermometer. Freezer and cooler temperatures should never be taken from the external thermometer...Read the thermometer and document the temperature under the appropriate date on the log...Temperature logs are maintained with the menus for a period of one year...Internal thermometers should be placed at the front of each unit, as this is considered the warmest part		designee will conduct observational audits of the kitchen and serveries 3 times per week for 4 weeks, then 2 times per week for 4 weeks, then weekly for 4 weeks to ensure safe food handling is maintained, including food be discarded by the manufacturers use by date; as well as the proper use of hairnets. The ED or designee will conduct observational audits of all dish machines, refrigerators, and freezers temp logs 3 times per week for 4 weeks, then 2 times per week for 4 weeks, then weekly for 4 weeks to ensure proper temperature readings and functionality. Results of the audits will be discussed in the monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going.	

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	due to opening the door allowing warmer temperatures to enter the space...Dishwasher temperature logs differ for low temperature (chemical) or high temperature machines. It is important to use the appropriate form based on the type of machine in the community...Report improper temperatures immediately...." A document titled "Four Factors that Directly Cause Food to Become Unsafe", undated, was provided by the Administrator on 4/18/23 at 2:28 p.m. The document indicated the following, "...Poor Personal Hygiene...This is the largest risk for developing foodborne illnesses. The best personal hygiene practices include hand washing, covering cuts or sores and covering hair (this includes beards)...."			
R 0274 Bldg. 00	410 IAC 16.2-5-5.1(g)(1-3) Food and Nutritional Services - Noncompliance (g) There shall be an organized food service department directed by a supervisor competent in food service management and knowledgeable in sanitation standards, food handling, food preparation, and meal service. (1) The supervisor must be one (1) of the following: (A) A dietitian. (B) A graduate or student enrolled in and within one (1) year from completing a division approved, minimum ninety (90) hour classroom instruction course that provides classroom instruction in food service supervision who has a minimum of one (1) year of experience in some aspect of institutional food service management. (C) A graduate of a dietetic technician program approved by the American Dietetic Association.			

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	(D) A graduate of an accredited college or university or within one (1) year of graduating from an accredited college or university with a degree in foods and nutrition or food administration with a minimum of one (1) year of experience in some aspect of food service management. (E) An individual with training and experience in food service supervision and management. (2) If the supervisor is not a dietitian, a dietitian shall provide consultant services on the premises at peak periods of operation on a regularly scheduled basis. (3) Food service staff shall be on duty to ensure proper food preparation, serving, and sanitation. Based on observation, interview, and record review, the facility failed to ensure staff were knowledgeable regarding sanitation standards of food handling, meal service, monitoring the use of a dish machine, monitoring of temperatures for a fridge/freezer, and the use of hairnets during meal service. This had the potential to affect all 30 residents that reside in the facility. Findings include: 1. The main kitchen was observed on 4/17/23 at 12:20 p.m. The main refrigerator was observed with the following: - A head of lettuce in a bag that was brown in color with liquid in the bag, - A box of lemons, dated 3/16/23, that had brown spots, - A box of pastries with no date that were covered with clear wrap, - A container of salsa dated 9/16/22, - A container of Caesar Salad dressing with a best	R 0274	R 274 Food and Nutritional Services – Noncompliance **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The lettuce, lemons, pastries, salsa, Caesar salad dressing, and vegetable base were discarded on 4/17/2023 by Dietary Assistant 4. Ecolab was called to service the dish machines on the first floor and third floor due low temperature on 5/2/2023. RCP 3, RCP 8, and Director of Memory Care were retrained by the ED on 4/20/2023 on the kitchen and servery dress code, including wearing hairnets in the kitchen and servery	05/15/2023

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	by date of 1/12/23, A holding fridge had a container of vegetable base with a best by date of 11/19/22. An interview conducted with Dietary Assistant 4, on 4/17/23 at 12:35 p.m., indicated she would go the kitchen and throw away the items listed above. She commented on how corporate was in the facility a "few weeks ago" and looked through the kitchen. She couldn't answer the question regarding auditing the fridge for labels and/or dates. 2. The first floor Servery (Servery 1) was observed with a dish machine on 4/18/23 at 12:10 p.m. The dish machine had a sticker that indicated it was a chemical dishwasher with a recommended temperature of 120 degrees for wash and rinse cycle along with 50 ppm (parts per million) on the sanitation at a minimum. The temperature was reading 108 degrees and went up to 113 degrees after another cycle. An observation conducted on 4/18/23 at 1:30 p.m. of Servery 1 indicated the dish machine was on and in the process of cleaning dishes. The temperature was noted at 107 degrees. There were no logs located in Servery 1 for the dish machine. 3. The third floor Servery (Servery 2) was observed on 4/18/23 at 12:25 p.m. Resident Care Personnel (RCP) 3, RCP 8, and the Director of Memory Care were present and preparing the cooked food onto plates. All three of them were not wearing a hairnet. The Director of Nursing (DON) came shortly after and directed the three staff members to obtain a hairnet while serving		(Attachment 3). **2. 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?** An observational audit of kitchen and servery were done on 4/30/2023 by the CSM to ensure no outdated food present. Issues identified during this audit were addressed at that time. Any outdated or unlabeled food was discarded at that time. **1.What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur?** The ED was re-trained by RDCS on 4/20/2023 to ensure adequate food storage regarding undated and expired food in the main kitchen and serveries, to ensure functionality of the dishwasher, the use of hairnets, and to ensure a thermometer is in all refrigerators and freezers (Attachment 1). The	

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	food. RCP 3 obtained a hairnet, but RCP 8 and the Director of Memory Care proceeded to prepare food without the use of a hairnet. There was a dish machine located in Servery 2. The dish machine had a sticker that indicated it was a chemical dishwasher with a recommended temperature of 120 degrees for wash and rinse cycle along with 50 ppm (parts per million) on the sanitation at a minimum. The dish machine was reading "Lo" on the gauge regarding temperature. An interview conducted with RCP 3, on 4/18/23 at 12:19 p.m., indicated "we don't take temperatures or have a log" when asked about the dish machine. The dish machine was run through a couple of cycles with the following temperature(s) noted: - First cycle at 102 degrees after rinse, - Second cycle at 108 degrees after rinse, & - Third cycle at 112 degrees after rinse. The fridge/freezer combo was observed in Servery 2 with 2 containers of what appeared to be orange juice with no date or label. There was a container of watermelon chunks with a sell by date of 4/10/23. There wasn't a thermometer in the refrigerator or freezer. There were 3 containers of what appeared to be lemonade noted on the counter being served to residents on the Memory Care Unit with no label or date noted. There was no temperature logbook located in Servery 2 regarding the dish machine and/or the fridge/freezer. A document titled "FOOD STORAGE GUIDELINES", undated, was provided by the Administrator on 4/18/23 at 11:25 a.m. The		DM was re-trained by the ED and RDCS on 5/2/2023 to ensure adequate food storage regarding undated and expired food in the main kitchen and serveries, to ensure functionality of the dishwasher, the use of hairnets, and to ensure a thermometer is in all refrigerators and freezers (Attachment 4). The dietary and clinical staff were re-trained by the CSM on 4/20/2023 to ensure the use of hairnets, ensure the proper temperature of the dish machine, refrigerator and freezer, and sanitation standards of food handling during meal service (Attachment 3). **1.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 ED is responsible for sustained compliance. The ED or designee will conduct observational audits of the kitchen and serveries 3 times per week for 4 weeks, then 2 times per week for 4 weeks, then weekly for 4 weeks to ensure safe food handling is maintained, including	

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	document indicated the following, "...1. Dating & Labeling...All food items must be labeled using food storage labels...Delivered food items must be labeled and received date...Prepared food items must be labeled with common name, prepared date and use by date...Guidelines to hold food...3 days - from preparation for prepared foods...7 days - from opening canned items like pudding, fruits, and vegetables...30 days - opened condiments like mayonnaise, ketchup, mustard, pickled foods, salad dressings, tomato products...." A document titled "Kitchen Appliance Temperature Logs", undated, was provided by the Administrator on 4/18/23 at 2:28 p.m. The document indicated the following, "...Appliance temperatures must be monitored daily and recorded on the Kitchen Appliance Temperature Log. Each appliance should have an internal appliance thermometer. Freezer and cooler temperatures should never be taken from the external thermometer...Read the thermometer and document the temperature under the appropriate date on the log...Temperature logs are maintained with the menus for a period of one year...Internal thermometers should be placed at the front of each unit, as this is considered the warmest part due to opening the door allowing warmer temperatures to enter the space...Dishwasher temperature logs differ for low temperature (chemical) or high temperature machines. It is important to use the appropriate form based on the type of machine in the community...Report improper temperatures immediately...." A document titled "Four Factors that Directly Cause Food to Become Unsafe", undated, was provided by the Administrator on 4/18/23 at 2:28 p.m. The document indicated the following, "...Poor Personal Hygiene...This is the largest risk		food be discarded by the manufacturers use by date; as well as the proper use of hairnets. The ED or designee will conduct observational audits of all dish machines, refrigerators, and freezers temp logs 3 times per week for 4 weeks, then 2 times per week for 4 weeks, then weekly for 4 weeks to ensure proper temperature readings and functionality. Results of the audits will be discussed in the monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going.	

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	for developing foodborne illnesses. The best personal hygiene practices include hand washing, covering cuts or sores and covering hair (this includes beards)...."			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to have complete documentation regarding a wound treatment that was completed by facility staff without a physician order for 1 of 8 residents records reviewed. (Resident R30) Findings include: The clinical record for Resident R30 was reviewed on 4/18/23 at 11:45 a.m. The diagnoses included, but were not limited to, urinary retention, dementia, and anxiety. A resident service note, dated 3/14/23 at 9:00 a.m., indicated the following, "...Noted R [right] heel dark area 2.5 cm [centimeters] x 2.5 cm, tender to touch...." A resident service note, dated 3/15/23 at 10:00 a.m., indicated a nurse with a home health company came to assess the wound to Resident R30's right heel. The wound was a blister that was	R 0349	R 349 Clinical Records – Noncompliance **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** A physician order was obtained by CSM for Resident R30 wound treatment on 4/20/2023. **2. 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?**	05/15/2023

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	then open. Home health will be doing the treatment to the right heel. A third-party caregiver charting form was implemented for home health services. The following forms were noted: - 3/15/23- indicated wound care provided to right heel and new orders noted, - 3/17/23- indicated wound care was provided, - 3/20/23- indicated wound care was provided, - 3/23/23- indicated wound care was provided, & - 3/27/23- indicated wound care was provided. There were no physician orders in Resident R30's clinical record regarding a treatment for the right heel. A resident service note, dated 3/22/23 at 8:30 p.m., indicated Resident R30's right heel dressing was changed by the facility's nursing staff. There was no indication of what the dressing was changed with or what was applied to Resident R30's right heel. An interview conducted with the Director of Nursing (DON), on 4/18/23 at 2:13 p.m., indicated Resident R30's wound was managed by home health, and they (home health) were the ones supposed to change the dressing. If there were no orders for the facility staff to change it, then we don't change it. It's left up to home health.		CSM completed an audit on 4/29/2023 of all resident records to ensure physician orders are in place for all wound treatments and that documentation is complete. No other findings during this audit. **1.What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur?** The CSM was re-trained by RDCS on 4/20/2023 to ensure community has a physician order for all wound treatments and to ensure the documentation regarding the wound treatment is complete (Attachment 2). The licensed staff were re-trained by CSM on 4/20/2023 to ensure community has a physician order for all wound treatments and to ensure the documentation regarding the wound treatment is complete (Attachment 3). **1.How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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			recur, i.e., what quality assurance program will be put into place? The CSM is responsible for sustained compliance. The CSM or designee will audit 5 resident treatment orders and documentation for treatments weekly for 4 weeks, bi-weekly for 2 months, then monthly for 1 month to ensure community has a physician order for all wound treatments and to ensure the documentation regarding the wound treatment is complete. The audits will be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going. !--[if !supportAnnotations]-->	
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview, and record review, the facility failed to ensure infection control practices were maintained during meal	R 0414	R 414 Infection Control – Deficiency 1. What corrective action(s) will be	05/15/2023

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	service for 2 of 3 residents observed for meal service. (Resident R20 and Resident R27) Findings include: An observation was conducted of meal service on the Memory Care Unit, on 4/18/23 at 12:25 p.m. There was Licensed Practical Nurse (LPN) 5 seated at a table with Residents R27, R24, and R20. LPN 5 proceeded to assist Resident R27 with eating by utilizing utensils and then assisted Resident R20 with cutting up her food without performing hand hygiene between resident contact. Resident R27 dropped some pieces of food on her shirt and LPN 5 picked up the food items and continued to assist Resident R27 with eating and encouraging Resident R20 to eat her food and touched her glass cups while encouraging her to eat. A document titled "Hand Washing", undated, was provided by the Administrator on 4/18/23 at 2:28 p.m. The document indicated the following, "...Wash hands and wrists up to forearms, including under fingernails, vigorously and with soap and hot water for a minimum of 20 seconds upon each situation...Immediately before preparing food or handling equipment...Before putting gloves on, and after taking gloves off...As often as necessary, whenever contamination occurs...After touching face, hair, or any body part...Between each task performed...."		accomplished for those residents found to have been affected by the deficient practice? LPN 5 was re-trained by CSM on 4/20/2023 to ensure infection control practices were maintained during meal service (Attachment 3). 2. 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? An observational audit of infection control practices during meal service, by current staff was conducted on 4/20/2023 by CSM. Findings were corrected at this time. 3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur? The CSM was re-trained by RDCS on 4/20/2023 to ensure infection control practices are maintained during meal service (Attachment 2). All clinical staff were re-trained on 4/20/2023 by CSM to ensure infection control practices are maintained during meal service (Attachment 3). 4. How the corrective action(s) will	

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			be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The CSM is responsible for sustained compliance. The CSM or designee will complete observational audits of infection control practices during meal service 3 times weekly for 4 weeks, 2 times weekly for 4 weeks, then weekly for 4 weeks to ensure infection control practices are maintained during meal service. The audits will be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going.	