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	07/03/2024

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RITTENHOUSE VILLAGE AT NORTHSIDE	1251 W 96TH ST INDIANAPOLIS, IN 46260

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00427840. Complaint IN00427840 - No deficiencies related to the allegations are cited. Survey dates: July 2 and 3, 2024. Facility number: 003282 Residential Census: 78 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on July 12, 2024.	R 0000		
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 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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dan Fink	Executive Director	08/09/2024

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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	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 the fire department was invited to attend a facility fire and disaster drill every six months during the last 12 months reviewed for fire and disaster. Finding includes: The fire and disaster drill documentation were reviewed on 7/2/2024 at 9:44 a.m. There was no documentation found to show the facility had invited the fire department to attend a fire and disaster drill at least every six months in the past 12 months. During an interview, on 7/2/24 at 10:46 a.m., Maintenance Employee 1 indicated the fire department had not been invited to attend a fire and disaster drill at least every six months and he was not aware it needed to be done. During an interview, on 7/3/24 at 5:02 p.m., the Executive Director indicated the facility followed the state regulations. A facility policy, titled "FIRE DRILL POLICY-POLICY AND PROCEDURE," undated and received from the Director of Nursing on 7/3/24 at 4:16 p.m., did not cover inviting the fire department every six months to observe a fire and disaster drill.	R 0092	R092 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? *The facility will leverage an existing information system, TELS, to ensure bi-annual drills occur with the invitation of the local fire department.* 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 facility has identified that 100% of the residents had the potential to be affected by the 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 facility will enter the bi-annual fire drill that includes an invitation to the local fire department into the facilities information system, TELS, to ensure that the Director*	09/01/2024

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			of Facilities and Executive Director receive a computerized bi-annual reminder of the need to invite the local fire department to an upcoming fire drill. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and *The Director of Facilities will demark in the TELS system documentation of the actual fire drills of the participation of the local fire department in bi-annual drills, including the name, title and badge number of the attending fireman attending each drill and any recommendations of those persons to improve the drills and responses.* By what date the systemic changes will be completed. *The systemic change will be accomplished by September 1, 2024, with the first drill including an invitation to the local fire department also occurring in September, 2024.*	
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			

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	a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on interview and record review, the facility failed to ensure background and reference checks were completed for 4 of 5 new employees reviewed for employee files. (CNA 3, the Activity Director, Housekeeper 5 and CNA 6) Findings include: The employee records were reviewed on 7/3/24. 1. CNA 3 was hired on 12/29/23. The facility was unable to provide documentation to show a criminal background check or reference checks had been completed on the employee prior to employment. 2. The Activity Director was hired on 1/29/24. The facility was unable to provide documentation to show reference checks had been completed on the employee prior to employment. 3. Housekeeper 5 was hired on 9/20/23. The facility was unable to provide documentation to show reference checks had been completed on the employee prior to employment. 4. CNA 6 was hired on 1/30/24. The facility was unable to provide documentation to show a criminal background check or reference checks had been completed on the employee prior to employment. During an interview, on 7/3/24 at 2:26 p.m., the Business Office Manager indicated she had provided all the employee record information she could provide. She was told by another employee, the previous Business Office Manager shredded	R 0116	R116 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? *Facility will audit all team member/employee records using the format provided by the ISDH surveyor to ensure all elements required by the regulations of the State of Indiana are included and current in each team member's file.* 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 facility has identified that 100% of residents had the potential to be affected by the deficiency.* 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 Executive Director will complete a 100% audit of employee files using the ISDH tool provided by the surveyor to ensure completeness, accuracy and timeliness of files. After the initial audit, all remaining*	10/01/2024

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	employee information. A policy was requested. An email document from the Division Director of Human Resources, dated 7/3/24 at 3:07 p.m., and received from the Business Office Manager indicated "...After researching our files...you can advise...that we follow the state regulations. We do not have additional policies above that...."		*deficiencies will be corrected within one week of the results of that audit. Quarterly, throughout the remaining calendar year, the Executive Director will repeat the audit of the employee files to ensure 100% compliance with the ISDH tool provided by the surveyor. Final verification will come in the form of no deficiencies upon annual survey in 2025.* *The Executive Director, through the audit process, will also ensure the Business Office Manager strictly and continuously follows all company policies and procedures and ISDH standards regarding creation and maintenance of employee files* How the corrective actions 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 Director will monitor audits quarterly until the next annual ISDH survey to ensure the deficient practice does not recur.* By what date the systemic changes will be completed. *The first and initial 100% audit will be completed by October 1, 2024, and completed quarterly until the next annual ISDH survey in 2025.*	

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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 shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure at least one staff member certified in First Aid and Cardiopulmonary Resuscitation (CPR) was on the premises for 1 of 21 shifts reviewed. Finding includes: The staff schedule was reviewed on 7/3/24. The facility was unable to provide documentation to show there was one staff member certified in CPR and first aid in the facility on 6/24/24 between 10:00 p.m. and 6:00 a.m.	R 0117	*R117* What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Appropriate numbers of community staff will be professionally trained in both CPR and First Aid to ensure the standard is met. How will the facility identify other	08/19/2024

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	During an interview, on 7/3/24 at 4:16 p.m., the Director of Nursing indicated she was unable to provide documentation to show there was CPR and first aid coverage on the night shift for 6/24/24. A facility policy, titled "Staffing, Emergency Training, Cardiopulmonary Resuscitation (CPR) and First Aid Training," dated 12/1/23 and received from the Director of Nursing on 7/3/24 at 4:16 p.m., indicated "...Each Community must have at least one (1) staff member trained in Cardiopulmonary Resuscitation (CPR) and First Aid on-duty and on the premises at all times...."		residents having the potential to be affected by the same deficient practice and what corrective action will be taken? *The facility has determined that 100% of residents had the potential to be affected by this deficiency.* 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 Director of Health and Wellness will organize for on-site professional training of adequate staff to meet the standard. She will also demark on every health and wellness staff schedule which staff member is properly trained and certified in CPR and first Aid for each shift.* How the corrective actions 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 Director will review documentation of the professional training, which staff members attended and successful were certified in both CPR and First Aid, and also, for a minimum of one month, review the Health and Wellness staff schedule to ensure demarcation of the staff member appropriately certified in First Aid and CPR on each shift.*	

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			The Director of Health and Wellness will maintain a permanent and ongoing record of all staff members appropriately certified in both First Aid and CPR with a copy of the certification card or certificate. Should the community anticipate falling short of sufficient staff to meet the standard, then additional professional on-site CPR/First Aid training will be offered to enough staff to continuously meet the standard. By what date the systemic changes will be completed. *The initial professional First Aid/CPR training was offered to and completed by 18 staff on July 31, 2024. The Director of Health and Wellness is currently collecting the official cards/certificates for each attending staff member. She will initiate marking on the Health and Wellness staff schedule the staff member on each shift with appropriate certification by August 19, 2024.*	
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			

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	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 interview and record review, the facility failed to ensure new employees had received training in resident rights and six (6) hours of dementia training for 4 of 5 new employees reviewed for employee records. (CNA 3, the Activity Director, Housekeeper 5 and CNA 6) Findings include: The employee records were reviewed on 7/3/24.	R 0120	*R120* What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? *The Executive Director and Business Office Manager will engage the existing Relias Learning system to monitor staff*	09/30/2024

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	1. CNA 3 was hired on 12/29/23. The facility was unable to provide documentation to show the employee was in-serviced on resident rights. 2. The Activity Director was hired on 1/29/24. The facility was unable to provide documentation to show the employee was in-serviced on resident rights. 3. Housekeeper 5 was hired on 9/20/23. The facility was unable to provide documentation to show the employee was in-serviced on resident rights. The employee had received 4.5 hours of the required 6 hours of dementia training. 4. CNA 6 was hired on 1/30/24. The facility was unable to provide any documentation to show the employee was in-serviced on resident rights. During an interview, on 7/3/24 at 2:26 p.m., the Business Office Manager indicated she had provided all the employee record information she could provide. She was told by another employee, the previous Business Office Manager shredded employee information. A policy was requested. An email document from the Division Director of Human Resources, dated 7/3/24 at 3:07 p.m., and received from the Business Office Manager indicated "...After researching our files...you can advise...that we follow the state regulations. We do not have additional policies above that...."		*compliance with staff member training in both resident rights and dementia training for all new staff members.* 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 facility has determined that 100% of the residents had the potential to be affected by the deficiency.* 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 existing Relias Learning system provides the ability for the Executive Director and the Business Office Manager to regularly monitor compliance by all staff members, including new staff members, regarding required resident rights and dementia training* How the corrective actions 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 Director, though monthly monitoring, will ensure 100% compliance with required training for new employees and maintain detailed records of the*	

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			training for review at any time, including name of the training unit and certified hours of the training. By what date the systemic changes will be completed. *Systemic changes through use of the Relias Learning System will begin immediately. Assurance of 100% compliance by new staff members will be completed by September 30, 2024 for existing/new staff members and monthly for any ensuing new staff member in September 2024 and following.*	
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			

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	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. (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 interview and record review, the facility failed to ensure new employees had received a two-step tuberculosis (TB) screening for 2 of 5 new employees reviewed for TB. (CNA 3 and CNA 6) Findings include: The employee records were reviewed on 7/3/24. 1. CNA 3 was hired on 12/29/23. The facility was unable to provide documentation to show the employee had received a 2-step tuberculosis test. 2. CNA 6 was hired on 1/30/24. The facility was unable to provide any documentation to show the employee had received a 2-step tuberculosis test. During an interview, on 7/3/24 at 2:26 p.m., the Business Office Manager indicated she had provided all the employee record information she	R 0121	R121 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? *The Director of Health and Wellness will ensure that all new employees receive the 2-step tuberculosis test prior to resident contact. Existing employees lacking this test will be asked to complete the test.* 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 facility has determined that 100% of the resident had the*	10/01/2024

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	could provide. She was told by another employee, the previous Business Office Manager shredded employee information. A policy was requested. During an interview, on 7/3/24 at 3:50 p.m., the Director of Nursing indicated new employees were to receive a two-step tuberculosis screening. A facility policy, titled "Infection Control Communicable Diseases," dated as last reviewed 2/1/24 and received from the Director of Nursing on 7/2/24 at 2:40 p.m., indicated "...The Community will...Ensure Employees, prior to placement, obtain a TB test (or CXR, if appropriate) and complete TB risk assessment and TB Screening...."		*potential to be affected by the deficiency.* What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? *Through the audits recommended in the Plan of Correction for R116, the Executive Director will regularly audit compliance with the standard and compel compliance if any deficiencies are found. The Business Office Manager will additionally monitor compliance during the new hire onboarding process, document any deficiencies to the Executive Director, and send those deficient employees back to the Director of Health and Wellness for the 2-step tuberculin test.* How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and *Corrective actions will be monitored through the above referenced monitoring process also outlined in R116's Plan of Correction. This monitoring will be ongoing and not time-bounded and ultimately verified by the next ISDH annual survey in 2025.* By what date the systemic changes will be completed.	

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			The first and initial 100% audit will be completed by October 1, 2024, and completed quarterly until the next annual ISDH survey in 2025. The Executive Director will commence auditing all new hire documentation through the new hire check sheet provided by the company and completed by the Business Office Manager. The ED will sign and date each checklist to verify compliance. This monitoring will occur on an ongoing basis and not be time-bounded.	
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on interview and record review, the facility	R 0123	R123	10/01/2024

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	failed to ensure new employees received general and job specific orientation for 4 of 5 employees reviewed for orientation. (CNA 3, the Activity Director, Housekeeper 5 and CNA 6) Findings include: The employee records were reviewed on 7/3/24. 1. CNA 3 was hired on 12/29/23. The facility was unable to provide documentation to show the employee received general orientation of the facility or job specific training. 2. The Activity Director was hired on 1/29/24. The facility was unable to provide documentation to show the employee received general orientation of the facility or job specific training. 3. Housekeeper 5 was hired on 9/20/23. The facility was unable to provide documentation to show the employee received general orientation of the facility or job specific training. 4. CNA 6 was hired on 1/30/24. The facility was unable to provide documentation to show the employee received general orientation of the facility or job specific training. During an interview, on 7/3/24 at 2:26 p.m., the Business Office Manager indicated she had provided all the employee record information she could provide. She was told by another employee, the previous Business Office Manager shredded employee information. A policy was requested. An email document from the Division Director of Human Resources, dated 7/3/24 at 3:07 p.m., and received from the Business Office Manager indicated "...After researching our files...you can		What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? *The Executive Director and Business Office Manager will ensure appropriate organization and documentation of both new hire general and department-specific orientation for all new employees.* How the facility wil identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? *The facility has determined that 100% of residents have the potential to be affected by the deficiency.* What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? *Through the audits recommended in the Plan of Correction for R116, the Executive Director will regularly audit compliance with the standard and compel compliance if any deficiencies are found. The Business Office Manager will additionally monitor compliance during the new hire onboarding process, document any deficiencies to the Executive Director.* *The Executive Director will*	

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	advise...that we follow the state regulations. We do not have additional policies above that...."		*additionally monitor compliance with department-specific orientation through documentation from department managers regarding compliance with the standard. The company provides detailed documents to utilize to properly complete these functions. Department managers will be required by the Executive Director to utilize these tools and document their utilization.* How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and *Corrective actions will be monitored through the above referenced monitoring process also outlined in R116's Plan of Correction. This monitoring will be ongoing and not time-bounded and ultimately verified by the next ISDH annual survey in 2025.* By what date the systemic changes will be completed. *The first and initial 100% audit will be completed by October 1, 2024, and completed quarterly until the next annual ISDH survey in 2025. The Executive Director will commence auditing all new hire documentation through the new hire check sheet provided by the company and completed by the Business Office Manager. The ED will sign and date each*	

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			checklist to verify compliance. This monitoring will occur on an ongoing basis and not be time-bounded.	
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 comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on interview and record review, the facility failed to provide documentation of an annual Heating, Ventilation and Air Conditioning (HVAC) inspection during the last 12 months. Finding includes: The documentation for the annual HVAC inspection was requested during the Entrance Conference on 7/2/24. During an interview, on 7/2/24 at 10:46 a.m., Maintenance Employee 1 indicated he did not have an HVAC inspection and was in contact with the Regional Maintenance person to see if he	R 0148	R148 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? *The facility will deploy an outside contractor to annually inspect the Heating, Ventilation and Air Conditioning (HVAC) system.* 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?	08/31/2024

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	could find one. During an interview, on 7/2/24 at 12:28 p.m., Maintenance Employee 1 indicated the facility did not have documentation of an annual HVAC inspection. A facility policy for annual HVAC inspection was requested on 7/2/24 at 12:29 p.m. and 3:50 p.m., and 7/3/24 at 3:45 p.m. During an interview, on 7/3/24 at 5:02 p.m., the Executive Director indicated the facility followed the state regulations. The facility did not provide a policy.		*The facility has determined that 100% of the residents had the potential to be affected by the deficiency.* 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 Director of Facilities will enter into the facilities information system, TELS, electronic reminders of the requirement for an annual HVAC inspection.* How the corrective actions 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 Director and Director of Facilities will ensure that the annual HVAC inspection occurs and is appropriately documented in the TELS system including any report of deficiencies provided by the contractor and documentation of correction of the reported deficiencies in the TELS system.* By what date the systemic changes will be completed. *The reminders of the requirement for an annual HVAC system inspection will be entered in to the TELS system by August 31, 2024. The actual annual inspection of the HVAC system is*	

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			scheduled to be accomplished by August 31, 2024 by an outside contractor.	
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 staff wore hair coverings in the kitchen, failed to cover equipment which was not in use, failed to put dates on items when they were opened, failed to maintain a thermometer in the freezer and walk in cooler, failed to monitor freezer temperatures, failed to clean a refrigerator, failed to ensure food/drinks were sealed from air in the pantry, on shelves and in refrigerators, failed to label items stored in the refrigerator, failed to keep the floor clear of items in the pantry, failed to date canned items with the date they were received, failed to remove a damaged can from storage and failed to clean the walls, food preparation tables, and floors of debris and/or grease in 1 of 1 kitchen reviewed for a safe and sanitary environment. Findings include: 1. During an observation of food service, on 7/2/24 at 12:12 p.m., Staff Member 52 was observed in the serving kitchen standing next to	R 0273	R273 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? *Facility will engage the Regional Chef within the company with the Executive Director to develop comprehensive action plans to address all of the listed deficiencies.* 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 facility has determined that 100% of residents had the potential to be affected by the deficiencies.* What measures will be put into	09/30/2924

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	the heating/cooling table which contained the lunch meal without a hair cover over her hair. The food was noted to be uncovered by any lids. During an interview, on 7/2/24 at 12:13 p.m., Staff Member 52 indicated staff was not to be in the kitchen area without a hair cover, she did not work in the kitchen, and she was in the serving area, without a hair cover. 2. During an observation of the kitchen, on 7/3/24 at 8:23 a.m., a storage bin, located on the shelf of the food preparation table, contained sugar which was found open to air. At the time, the sugar was not in use. The large stand mixer, which was not currently in use, was found without a cover. During an interview, on 7/3/24 at 8:23 a.m., the Executive Director indicated the stand mixer should have been covered and the sugar bin should have been closed. 3. During an observation of the kitchen, on 7/3/24 beginning at 9:06 a.m., the following items were observed: a. Freezer 1 was found without a thermometer on the inside of the unit. There was no temperature log for Freezer 1. During an interview, on 7/3/24 at 9:07 a.m., Cook 2 indicated there was no temperature log for the freezer and she did not know if she was to check the freezer temperatures. b. Freezer 1 was found to have three (3) gallon containers of vanilla ice cream and a three (3) gallon containers of coffee ice cream without open dates. Both containers had been opened and used.		place or what systemic changes the facility will make to ensure that the deficient practice does not recur? *The Executive Director will initially work in collaboration with the company's Regional Chef to develop a sequential action plan, with associated deadlines, for addressing each of the listed deficiencies. As deficiencies are addressed, the action taken, and inspection report will be maintained by the Executive Director.* *The Executive Director will recruit a new Executive Chef to routinely oversee compliance with the standards. The Executive Chef will be properly trained in food management and safety and provide documentation of his or her training. The Regional Chef will visit the community monthly for the first quarter after the Executive Chef hiring to ensure compliance with the plan of action for meeting all standards and documenting his inspection as well as any additional required actions to meet the plan/standards. The Executive Director will supervise the Executive Chef to ensure compliance with the plan/standards on the planned timelines and per plan specification for food management and safety.* *The Regional Chef will*	

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	c. Refrigerator 2 was found without a thermometer in the unit. There were four clear plastic pitchers, each containing fluids: red, yellow, dark red and orange. The pitchers had not been labeled to indicate what the fluid was and there were no dates on the pitchers. The refrigerator was observed to have dried fluids up the walls and on the racks. Also observed was a one-gallon container of decaffeinated iced-tea, ½ full, and a one-gallon container of unsweetened ice-tea, ¼ full. Both containers did not have open dates. There was a container of sliced ham loosely wrapped with part of the meat exposed to air, two containers of cranberry base, one container of apple juice base and one container of orange juice base. All the cartons had been ripped on one corner side exposing them to air. During an interview, on 7/3/24 at 9:17 a.m., Cook 2 indicated the sliced ham was supposed to be stored in a different cooler and the juice bases needed to be wrapped/sealed and not left open to air in the refrigerator. d. In the freezer by the stove, there was a clear pitcher without a label or date. The pitcher was full, and the contents were frozen. A plastic bag with frozen biscuits, a bag of hash browns, a bag of sausage patties and a bag of French fries were all found open to air and without open dates. e. The walk-in cooler was found to have a plastic cover for a thermometer, but the thermometer was missing. The cooler also contained a package of hot dogs open to air and a 16.7-ounce container of caramel sauce, half full and without an open date. f. The pantry was found to have a box of paper cups stored on the floor, a 10-pound box of		*subsequently visit the community quarterly until the next ISDH annual survey to ensure compliance with the standards and to provide written feedback to the Executive Director about any identified deficiencies. The Regional Chef will also assure that any identified quarterly deficiencies are 100% addressed per his/her instruction of his/her next quarterly formal inspection visit to the community.* How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and *The Regional Chef and Executive Director will concomitantly monitor compliance with improvement plans until 100% compliance is achieved and maintained.* By what date the systemic changes will be completed. *The Executive Director and Regional Chef will begin immediately developing and implementing an action plan to address standard deficiencies as evidenced by a written action plan with associated due dates for action items.* *Recruitment of a new Executive Chef to provide routine leadership of the department is currently underway and anticipated to be completed by September 30, 2024*	

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	raisins, half full, open to air and two one-gallon bottles of syrup, approximately 1/8 full, without open dates. On the rack which contained bulk cans, 38 of 53 cans were found without dates to indicate when they were received, and one 6.6 pound of pumpkin filling was found dented along the upper seam. During an interview, on 7/3/24 at 9:50 a.m., Cook 2 indicated the facility was short-staffed in the kitchen. She did have a current SERVSAFE (a certification which verified the manager or person-in-charge had sufficient food safety knowledge to protect the public from foodborne illness). Labeling/dating food, keeping food from air exposure, using thermometers in refrigerators and freezers and checking the unit temperatures were covered in the certification program. It was the responsibility of the person(s) holding the certification to ensure the kitchen was maintained to the standards of the [state] regulations. 4. On 7/3/24 at 9:39 a.m., the dishwasher was observed for proper working condition. The wash cycle reached 108 degrees Fahrenheit. There was no information sticker located on the machine to indicate what the proper wash and rinse temperatures were to ensure the dishes were properly cleaned. During an interview, on 7/3/24 at 9:41 a.m., Cook 2 was not able to say what the wash temperature or rinse temperatures were supposed be to properly clean the dishes. She indicated the dishwasher was running correctly earlier that morning. 5. On 7/3/24 at 9:44 a.m., grease was observed on the wall behind the fryer and steamer, the food preparation tables had debris on the shelves used to store kitchen items and debris, food and a black		*including through training of the Executive Chef by both the Regional Chef and the Executive Director.*	

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	substance was found along the baseboards of the kitchen. At that time, Cook 2 indicated staff were supposed to clean the kitchen. A facility policy, titled "FOOD STORAGE GUIDELINES," undated and received from the Director of Nursing on 7/3/24 at 3:50 p.m., indicated "...All food items must be labeled using food storage labels...Delivered food items must be labeled with received date to follow FIFO (first in, first out) rules...Prepared food items must be labeled with...use by date...." A facility document, titled "SECTION 1: SPECIFICATION INFORMATION ES-2000 SERIES SPECIFICATIONS," dated as issued 10/29/2007 and received from the Director of Nursing on 7/2/24 at 3:58 p.m., indicated "...TEMPERATURES...WASH... F (Fahrenheit)...120...(RECOMMENDED) 140...." A facility policy, titled "Personal Appearance Policy," undated and received from the Executive Director on 7/3/24 at 10:23 a.m., indicated "...Proper hair covering (ex., hairnet, baseball cap, etc.) must be worn...." A facility policy, titled "DINING OPERATIONS BEST PRACTICE," undated and received from the Director of Nursing on 7/3/24 at 3:41 a.m., indicated "...Maintain logs documenting the temperature monitoring and storage of perishable food items...during storage. This includes records of refrigerator and freezer temperatures...Hygiene and Food Safety...The community must maintain high standards of cleanliness and food safety. This includes regular cleaning and sanitation of food preparation and storage areas...Temperature			

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	control measures: Fridges has to be below 40 and freezers below 0 Fahrenheit. Temperatures should be taken twice a day...Maintain 3 months of accurate and up-to-date records related to food safety, including temperature logs...Cans with...flawed seals or seams, rust, dents, or leaks...Dented cans are kept in a designated location (labeled "dented cans") until the vendor can pick them up...MIXER After each use...Cover bowl with clear plastic (food safe) bag...REFRIGERATOR...Wipe up spills on the exterior and interior of the unit as they occur...."			