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	08/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WICKSHIRE WEST LAFAYETTE	3575 SENIOR PLACE WEST LAFAYETTE, IN 47906

(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 Complaints IN00380382, IN00384689, IN00385699 and IN00379980. Complaint IN00380382 - Substantiated. State Residential Findings are cited at R273. Complaint IN00384689 - Substantiated - No deficiencies related to the allegations are cited. Complaint IN00385699 - Unsubstantiated due to lack of evidence. Complaint IN00379980 - Substantiated - No deficiencies related to the allegations are cited. Survey dates: August 9, 10, 11 and 12, 2022 Facility number: 014094 Residential Census: 57 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on August 17, 2022.	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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	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 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 record review and interview, the facility failed to attempt to hold a fire drill in conjunction with the local fire department at least every 6 months and the facility failed to hold fire drills for 11 of 12 months reviewed for fire drills. (July 2021 through June 2022) Finding includes: During a record review of the facility fire drills, on 9/11/2022 at 9:30 a.m., the facility failed to hold fire drills for 11 months. During a record review of the facility fire drills, on 9/11/2022 at 9:30 a.m., the facility failed to contact the local fire department in a 6 month period. During an interview, on 9/11/2022 at 11:19 a.m., the Director of Maintenance indicated there were no records of fire drills in the facility until July 2022. He indicated he was hired in July 2022 and he conducted the fire drill for July 2022.	R 0092	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice It is Wickshire West Lafayette intention to conduct scheduled fire and disaster drills per ISDH guidelines. All residents and staff have the potential to be affected by this alleged deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; The community will conduct monthly fire drill on each shift to ensure understanding and compliance by all. What measures will be put into place or what systemic changes the facility will make to ensure	08/31/2022

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	During an interview, on 9/11/2022 at 11:25 a.m., the Executive Director indicated she could not locate any fire drill records form July 2021 through June 2022.		that the deficient practice does not recur; Drills will then be conducted according to the established quarterly schedule. The Maintenance Director will be responsible for completion of the safety drills, maintaining records of drills and completing a drill report to the Executive Director. The Executive Director will be responsible for confirming that these drills take place per schedule and any concerns are addressed and resolved. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Executive Director/designee will review the fire and disaster drill logs monthly for two months. Findings will be reviewed at regularly scheduled QAPI meetings. The Executive Director may also request increased drills or monitoring as needed at any time. Systemic change will be completed 08/30/2022	
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for			

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	prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review and interview, the facility failed to make appropriate inquires for prospective employees in 5 of 5 employee files reviewed for references. (CNA 2, QMA 1, CNA 3, Cook 4 and Dining Manager 5) Findings include: 1. The employee record for CNA 2 was reviewed on 8/12/2022 at 10:00 a.m., the employee reference checks for CNA 2 were not in the employee file. 2. The employee record for QMA 1 was reviewed on 8/12/2022 at 10:05 a.m., the employee reference checks for QMA 1 were not in the employee file. 3. The employee record for CNA 3 was reviewed on 8/12/2022 at 10:10 a.m., the employee reference checks for CNA 3 were not in the employee file. 4. The employee record for Cook 4 was reviewed on 8/12/2022 at 10:20 a.m., the employee reference checks for Cook 4 were not in the employee file. 5. The employee record for Dining Manager 5 was reviewed on 8/12/2022 at 10:30 a.m., the employee reference checks for Dining Manager 5 were not in the employee file. During an interview, on 8/12/2022 at 1:25 p.m., the Executive Director indicated CNA 2, QMA 1, CNA 3, Cook 4 and Dining Manager 5 did not have any employee reference checks completed.	R 0116	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** All residents are at risk of being affected by this citing. The facility shall maintain current and accurate employee files. Reference checks should be completed on all new hires and remain in employee's file. **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;** Audit conducted by the Business Office Manager for all current employee files. The BOM will notify all current staff of any missing documents and schedule time for completion What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur BOM will complete monthly audit off all new employee files to ensure compliance with ISDH. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	09/12/2022

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			assurance program will be put into place; and Audits of employee files will be conducted by the Business Office Manager and reported at the QA meeting that will be held every third Thursday of the month to ensure compliance with ISDH. QA will cont. monthly x2 months and then quarterly with no end date. If any discrepancy is noted, it will be addressed at that time and reported to the ED. Systemic changes will be completed by 09/12/2022	
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			

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	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 record review and interview, the facility failed to ensure the staff on duty met the requirements of cardio pulmonary resuscitation (CPR) and first aid training certification. (19 of 21 shifts) Finding includes: A record review of the employee worked schedule, on 8/12/2022 at 9:45 a.m., indicated during the week of 8/2/2022 through 8/8/2022, the facility had 4 out of 21shifts without a first aid certified staff member in the facility. A record review of the employee worked schedule, on 8/12/2022 at 9:45 a.m., indicated during the week of 8/2/2022 through 8/8/2022, the facility had 15 out of 21shifts without a CPR certified staff member in the facility. During an interview, on 8/12/2022 at 4:08 p.m., the Director of Nursing indicated CPR and first aid training certified staff members were not on duty at the facility for the 19 shifts indicated on the staffing schedule reviewed for 8/2/2022 through 8/8/2022. During an interview, on 8/12/2022 at 10:30 a.m., the Executive Director indicated after final review of the records, CPR and first aid certified staff members were not on duty at the facility for the 19 shifts indicated on the staffing schedule reviewed for 8/2/2022 through 8/8/2022.	R 0117	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** All residents are at risk of being affected by this citing. A minimum of 1 awake staff person, with CPR and first aid certificates, shall be on site at all times. First Aid/CPR training will be completed by current nursing staff no later than 9/30/2022 to ensure compliance. **-How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** The Director of Nursing will be responsible for verifying that compliance is met daily on each shift. The facility will provide First aid and CPR certification onsite and be required by all current non-certified nursing staff **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** All newly hired nursing staff will complete First Aid/CPR training within 90 days of being hired. The Director of Nursing will track	09/30/2022

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			certification process to ensure compliance and verification of staff scheduled have certification. All nursing staff will be in-serviced on first aid and CPR regulations in a mandatory all-staff in-service no later than 9/30/2022.	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and			

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	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 record review and interview, the facility failed to perform a health screening for 5 of 5 employees and to ensure new personnel were screened for Tuberculosis (TB) using the two-step procedure skin test for 1 of 5 employees reviewed for employee records. (QMA 1, CNA 2, CNA 3, Cook 4 and Dining Manager 5) Findings include: 1. During a review of QMA 1's health record on 8/12/2022 at 2:25 p.m., the record indicated a hire date of 3/9/2022. A first step TB skin test was completed. No second step skin test was completed. There was no health screening completed. 2. During a review of CNA 2's health record on 8/12/2022 at 2:30 p.m., the record indicated a hire date of 5/2/2022. There was no health screening completed. 3. During a review of CNA 3's health record on 8/12/2022 at 2:38 p.m., the record indicated a hire date of 6/30/202. There was no health screening completed. 4. During a review of Cook 4's health record on 8/12/2022 at 2:44 p.m., the record indicated a hire	R 0121	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** All residents have the potential to be affected by this alleged deficient practice. All new employees will have 1st step administered on initial employment or prior. HR/designee to monitor & issue reminders to new hires to ensure 2nd step of TB testing is administered within 14 days of hire. **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;** All staff will be in-serviced on revised procedure in mandatory all-staff meeting on 09/20/2022. The Regional Nurse also in-serviced the Executive Director, Business Office Manager and Nursing Managers on the TB requirements. The Director of	09/12/2022

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	date of 1/25/2022. There was no health screening completed. 5. During a review of Dining Manager 5's health record on 8/12/2022 at 2:50 p.m., the record indicated a hire date of 5/16/2022. There was no health screening completed. During an interview, on 8/12/202 at 3:03 p.m., the Executive Director indicated the employees were missing a health screening and one staff member did not have the second step two of the two-step process for TB testing in orientation.		Nursing audited all current employee health records to ensure compliance. Any concerns were promptly addressed. **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 Business Office Manager, as coordinator of employee hiring & training processes, will ensure all new hires and current employees remain compliant with this regulation. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Business Office Manager/designee will audit/review all new hire personnel files and current employees, monthly, times 2 months. Any items of concern will be promptly resolved. BOM/designee will report compliance at regularly scheduled Quality Assurance meetings. Monitoring will be ongoing **By what date the systemic changes will be completed.** Systemic changes will be completed by 09/12/2022	
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,			

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	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 record review and interview, the facility failed to inspect the heating and ventilating system at least yearly. This deficiency had the potential to affect 57 of 57 residents. Finding includes: During a record review of the facility maintenance records, on 9/11/2022 at 10:00 a.m., the facility failed to have a yearly maintenance check for the heating and ventilation system. During an interview, on 9/11/2022 at 11:19 a.m., the Director of Maintenance indicated there were no records found for the heating and ventilation system maintenance for 2021 and 2022. During an interview, on 9/11/2022 at 11:25 a.m., the Executive Director indicated she could not locate any records from July 2021 through June 2022.	R 0148	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** All residents are at risk of being affected by citing. Facility shall the heating and ventilating systems shall be inspected. A documented log will be maintained for inspection. -How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; The maintenance director will review the TELs log daily and verify compliance of annual and federal regulations are met. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient**	09/30/2022

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			practice does not recur; Maintenance Director will review TELs service and inspection logs daily and complete outstanding items by Friday of each week. **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** Audits conducted by the maintenance director and will be reported at the QA meeting that will be held every third Thursday of the month to ensure compliance with ISDH. QA will cont. monthly x2 months and then quarterly with no end date. If any discrepancy is noted, it will be addressed at that time and reported to the ED.	
R 0151 Bldg. 00	410 IAC 16.2-5-1.5(h) Sanitation & Safety Standards -Noncompliance (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations. Based on record review and interview, the facility failed to ensure a resident's pet was current with regular examinations and vaccinations by a licensed veterinarian in 4 of 8 resident pets records reviewed. (Residents 2, 5, 6 and 7) Finding includes: The record review of resident pets vaccinations, on 8/12/2022 at 3:19 p.m., indicated the pets for Residents 2, 5, 6 and 7 had no current vaccination	R 0151	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Pets who are housed within the community should have periodic veterinary examinations and required immunizations. All residents have the potential to be affected by this alleged deficiency.	08/25/2022

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	records. During an interview, on 8/12/2022 at 3:29 p.m., the Executive Director indicated the current vaccination records for Resident 2, 5, 6 and 7's pets could not be located.		**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;** All residents with pet will have immunizations. An audit was conducted by Executive Director of pet records. Pet vaccinations for the 4 missing residents was attained on 08/25/2022. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** All current residents pet vaccinations will be checked monthly for updates needed. All new residents pet vaccinations will be attained prior to admission. A calendar for monthly pet records was created on 08/25/2022 for date due of vaccinations. **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** Activities director or designee will audit pet records monthly. If any discrepancy is noted, it will be addressed at that time and reported to the ED.	
R 0217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency			

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Bldg. 00	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on interview and record review, the facility failed to ensure a service plan was signed and dated by the resident or resident's representative for 1 of 7 residents reviewed for service plans. (Resident D) Finding includes: The record for Resident D was reviewed on 8/12/2022 at 1:05 p.m. Diagnoses included, but	R 0217	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** All service plan for will be by 09/01/2022 . How the facility will identify other residents having the potential to be affected by the same deficient	08/22/2022

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	were not limited to, atrial fibrillation, cirrhosis of the liver (alcoholic) and aphasia. A service plan was not signed by the resident for 2022. During an interview, on 8/12/2022 at 1:23 p.m., the Director of Nursing indicated the resident did have a service plan but it was not signed. The resident should sign the service plan when it was discussed with him and his family. She indicated the form should have been signed when it was discussed.		practice and what corrective action will be taken All residents have the potential to be affected by this deficiency. An audit of resident service plans will be completed by 08/31/2022. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** Education for Health and Wellness Director on the Service Plan policy was given 08/17/2022. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The Director of Wellness or designee will conduct an audit of 5 resident service plans weekly x 4 weeks then monthly x 2 months. Results of the audits will be brought to QA Committee meeting for review/recommendations. **By what date the systemic changes will be completed.** Systemic change took effect 08/22/2022.	
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 interview and record review, the facility failed to ensure food temperatures were checked	R 0272	**What corrective action(s) will be accomplished for those**	09/20/2022

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	prior to serving the meal on many occasions throughout the year. This deficient practice had the potential to affect 57 of 57 residents residing in the facility. Finding includes: During a record review, on 8/12/2022 at 4:48 p.m., of the serving temperature logs for the facility meals the following dates were missing: There were no records for September, October, November and December of 2021. There were no records for January, February, March 2 through 5 and 9 through 31, April 1 through 17, May and June of 2022. During an interview, on 8/12/2022 at 5:15 p.m., the regional Operational Specialist indicated the temperature records should have been completed prior to serving the meals. He indicated he could not locate the records for the dates listed above.		**residents found to have been affected by the deficient practice** It is the intention of Wickshire West Lafayette to follow established safe food handing guidelines including recording of food temperatures prior to service. All residents have the potential to be affected by this alleged deficiency. **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** Food temperatures at point of service will be recorded by dietary servers using the established tracking form. Any variances will be addressed to ensure safe serving of food. All dietary staff will be re-educated no later than 09/20/2022 at mandatory dietary staff meeting on appropriate food temps & procedures for recording such and how to address any variances to resolve temperature concern. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur** Compliance will be monitored by use of an audit process and tracking form. The Executive Director/designee will conduct this audit as follows: 3 times weekly	

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			for one month; weekly for two months and monthly thereafter. Any deficiencies found in the audits will be corrected at the time discovered and retraining provided to staff or additional monitoring conducted, as necessary, to ensure safe food serving temperatures. **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** Findings will be reported to the QAPI Committee for review and recommendations. By what date the systemic changes will be completed. All changes will be completed 09/20/2022, Director/designee will conduct this audit as follows: 3 times weekly for one month; weekly for two months and monthly thereafter.	
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 food was labeled and dated in the refrigerator, freezer, open kitchen area and the dry storage area in 1 of 1 kitchen and 1 of 1 serving kitchenette and failed to	R 0273	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**	09/20/2022

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	keep records of temperatures in the walk-in refrigerator, the walk-in serving area refrigerator and the kitchen refrigerator and freezer. This deficient practice had the potential to affect 57 of 57 residents. Findings include: During the tour of the kitchen, on 8/11/2022 at 2:13 p.m., the following observations were made: 1. The refrigerator in the kitchen was observed to have the following not dated items: a. One bag of lettuce not dated. b. Two bags of broccoli not dated. c. Four bags of sprouts not dated. d. One container of french dressing opened and not dated. Sauce was running down the sides of the container. e. One turkey not dated or labeled. f. Two taco meat packages not dated. 2. The reach-in refrigerator, near the cooking area, was observed to have the following not dated items: a. One large container of BBQ sauce opened and not dated. b. One package (pkg) of chopped onions opened, not sealed and not dated. c. One container of sour cream opened and not dated. d. One pkg of feta cheese opened, not sealed and not dated. e. One ham opened and not dated. f. One container of corn syrup opened, not sealed and not dated. g. Two containers of teriyaki sauce opened and not dated. h. Three bacon base opened and not dated. i. One bag of cut cabbage opened and not dated.		It is the intention of Wickshire West Lafayette to follow established safe food handing guidelines including recording of food temperatures prior to service. All residents have the potential to be affected by this alleged deficiency. **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;** Food temperatures at point of service will be recorded by dietary servers using the established tracking form. Any variances will be addressed to ensure safe serving of food. All dietary staff will be re-educated no later than 09/20/2022 at mandatory dietary staff meeting on appropriate food temps & procedures for recording such and how to address any variances to resolve temperature concern. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** Compliance will be monitored by use of an audit process and tracking form. The Executive Director/designee will conduct this audit as follows: 3 times weekly for one month; weekly for two months and monthly thereafter. **How the corrective action(s)**	

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	j. One bag of sliced cucumbers opened and not dated. k. One jar of lemon juice opened and not dated. l. One jar of pineapple juice opened and not dated. m. One jar of cole slaw opened and not dated. 3. The freezer was observed to have the following opened and not dated items: a. One pkg of mixed vegetables opened and not dated and in a clear pitcher on the shelf . Vegetables were not covered and had spilled onto the floor of the freezer. Staff picked up the pitcher from the shelf and spilled additional vegetables on the floor. No clean up of vegetables occurred during the tour. b. Two pkgs of meat not dated. c. Two pkgs of ground beef not dated. d. Six chicken patties opened and not dated. e. Three pkgs of corn not dated. f. Six cakes not dated. g. Twelve pkgs of peppers not dated. h. One container of ice cream opened and not dated. i. Three pkgs of hash browns opened and not dated. 4. The dry storage was observed to have a large water puddle not covered or marked and the following opened and not dated items: a. One flour tub had a drinking cup inside and was opened and not dated or sealed. b. One sugar tub had a drinking cup inside and was opened and not dated or sealed. c. One pkg of grits opened and not dated or sealed. d. One pkg of oreo crumbs opened and not dated. e. Three pkgs of rice crispy cereal not dated. f. Ten pkgs of hot dog buns not dated. One pkg was noted to have mold inside the pkg. g. One loaf of raisin bread opened and not dated		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Any deficiencies found in the audits will be corrected at the time discovered and retraining provided to staff or additional monitoring conducted, as necessary, to ensure safe food serving temperatures. Findings will be reported to the QAPI Committee for review and recommendations. **By what date the systemic changes will be completed.** Systemic changes will be completed by 09/20/2022	

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	or sealed. h. One pkg of hamburger buns not dated. i. Four pkgs of angel food cake mix not dated. j. One pkg of muffin mix opened, not dated and not sealed. k. One pkg of chocolate powder opened and not dated. 5. The serving area was observed to have dirty floors. The clean area and dirty areas were not well defined. There was a bucket of dirty rags and a soap bucket under the clean serving tray area. A rolling cart with dirty glasses and utensils were in the clean area near the serving trays. A toaster was not cleaned and was in the clean area. The coffee maker had leaked on the serving area countertop. A large puddle was noted. The walk-in refrigerator was observed to have the following opened and not labeled or dated items: a. One liquid container of something red, not labeled or dated and opened. b. One liquid container of something orange, not labeled or dated and opened. c. One liquid container of something brown, not labeled or dated and opened. d. One box of sour cream, opened, not dated and not sealed (30 pkgs). e. One box of jams, opened, not dated and not sealed (14 pkgs). f. One box of ranch dressing, opened, not dated and not sealed (20 pkgs). g. One jelly jar outdated as of 4/27/2022. h. Two cottage cheese tubs outdated as of 6/27/2022. i. One box of strawberries not dated. j. One large box of whipped spread opened and not dated. 6. The kitchen dishwashing area was observed to have the following:			

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	a. Dirty items were on the clean side of the wash area. b. Clean items were dirty with debris and sauces. c. Dirt was found underneath clean cups and glasses. d. Food was found on the floor, on the clean sidec, of the washing room area. e. Clean utensils were hanging on rack, near the stove, and were splashed with sauces and debris. f. The walls of the room were splashed with dirt, debris and sauces. 7. The log books for the refrigerators and freezers were reviewed and indicated the following: a. The kitchen walk-in refrigerator temperatures were missing for November 2021, March 24 through 31, 2022, April 1 through 16, June 1 through 4 and 17 through 20 and July 19 through 31. b. The walk-in refrigerator, near the cooking area, temperature dates were missing for September 29 and 30, 2021, October 2021, December 2021, January 2022, February 2022, March 28 through 31, April 1 through 16, and July 21 through 31, 2022. c. The freezer dates were missing temperature checks for October 2021, March 22 through 31, April 1 though 16, 2022, June 1 through 4, and 17 through 20 and July 19 through 31. d. The walk-in refrigerator in the serving area temperatures were missing for September, October, November and December 2021, and January, February, March 23 through 31 2022, April, May, June and July 19 through 31. During an interview, on 8/11/2022 at 4:20 p.m., the Dining Manager indicated all items should be sealed, labeled and dated when opened and when placed in the freezer and refrigerators. She indicated the dry storage area should not have			

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	cups in the containers and items should be sealed and dated. The Dining Manager indicated the coffee machine had had been leaking since 5/16/2022 and it had not been addressed by management staff. During an interview, 8/12/2022 at 4:55 p.m., the Regional Operational Specialist indicated the temperature records should have been completed. He indicated he could not locate the records for the dates listed above. This State Tag relates to complaint IN00380382.			