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	01/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VERMILLION PLACE	449 MAIN ST ANDERSON, IN 46016

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00246359 and IN00250501. Complaint IN00246359- Substantiated. State deficiencies related to the allegations are cited at R0092, R0120 and R0272. Complaint IN00250501- Unsubstantiated due to lack of evidence. Unrelated deficiencies are cited. Survey dates: January 29, 30 and 31, 2018 Facility number: 011970 Residential Census: 42 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completedon February 5, 2018.	R 0000	Preparation and/or execution of this Plan of Correction in general or any corrective action set forth herein, in particular, does not constitute an admission or agreement by Vermillion Place of the facts alleged or the conclusions set forth in the statement of deficiencies The Plan of Correction and the specific corrective actions are prepared and/or executed solely because of provisions of state laws. Vermillion Place desires this Plan of Correction to be consideredthe facility's Allegation of Compliance. Compliance is effective . This building respectfully requests consideration for paper compliance from the Plan of Correction.	
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			

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

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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	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 interview and record review, the facility failed to ensure quarterly fire drills were conducted on each shift at least 12 times per year for 4 of 12 months reviewed for fire drills. The facility also failed to make an attempt to coordinate a fire drill with the local fire department every 6 months. This deficiency had the potential to affect 42 of 42 residents residing in the facility. Findings included: Review of the Fire Drill Report Forms, the following fire drills were conducted during 2017: January 27 at 1:20 p.m., March 11 at 8:00 a.m., March 29 at 1:15 p.m., May 8 at 12:30 p.m., June 14 at 11:42 a.m., August 27 at 9:00 a.m., September, undated, at 5:15 p.m., November 20 at 4:10 p.m., and December 18 at 3:08 p.m. During an interview on 1/31/18 at 11:50 a.m., the Corporate Administrator indicated the Director of Nursing (DON) and the Maintenance Director (MD) coordinated the fire drills together and then scheduled them as needed. During an interview on 1/31/18 at 11:53 a.m., the	R 0092	1. There was no negative out come or harm to the 42 residents that had the potiential to be affected. 2. There are no other residents affected. 3. The Maintenance Director, or their designee, will conduct fire drills 12 times per year, quarterly on each shift. Fire drills held between 9pm and 6am may use a coded announcement. The Anderson Fire Department, Chief Dave Cravens, has been contacted again to hold a fire drill in conjunction with the facility. His response was, "I told you when you contacted me in November, that I would get with you in March to set a date." A date to be determined by the Fire Department is pending for April. 4. The Maintenance Director, or their designee, will put the Fire Drill report in the Fire Drill Binder in the office. The Manager, or their	02/20/2018

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	DON indicated she did not do anything with fire drills and the MD took care of scheduling them. During an interview on 1/31/18 at 12:09 p.m., the MD indicated he scheduled the fire drills during the day and evening shifts. He indicated he did not schedule any fire drills on third shift. He also indicated he had never attempted to coordinate a fire drill with the local fire department. On 1/31/18 at 12:09 p.m., the Corporate Administrator indicated she was never told an attempt to coordinate a fire drill with the local fire department was required. Review of a current, undated facility policy, titled "Emergency Policy & Procedure Manual," which was provided by the Executive Director on 1/31/18 at 12:51 p.m., indicated the following: "1. Fire Safety Guideline ...Fire Drills are held 12 times per year, quarterly on each shift. Drills conducted between the hours of 9 pm and 6 am may use a coded announcement....At least every six months, the facility will attempt to hold a drill in conjunction with the local fire department. A record will be maintained of each drill...." This State tag relates to Complaint IN00245359.		designee, will audit the Fire Drill Binder monthly for compliance, for 6 months. They will then audit the Fire Drill binder every 3 months for 6 months. Then randomly as needed. If non-compliance is found she will notify the Administrator. The Administrator, or their designee, will investigate to ensure Fire Drills are done as required. The Administrator or their designee, will randomly audit the Fire Drill Binder. 5. Completion by February 20, 2018.	
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			

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	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 any nursing staff member was Cardiopulmonary Resuscitation (CPR) certified or first aid certified for 16 of 16 nursing staff reviewed for CPR certification (DON QMA 1, QMA 2, LPN 3, LPN 4, QMA 5, CNA 6, CNA 7, CNA 8, CNA 9, CNA 10, CNA 11, CNA 12, CNA 13,CNA 14, CNA 15). This deficiency had the potential to affect 20 of 42 residents residing in the facility that had full code status. Findings included: During an interview on 1/30/18 at 2:49 p.m., the Administrator indicated the Director of Nursing (DON) did the scheduling for the nursing staff. She indicated the DON made sure that at least one person on each shift was both CPR and first aid certified. She indicated the DON also monitored the CPR certificates. During an interview on 1/30/18 at 3:04 p.m., the	R 0117	1.Their was no negative out come for any of the 20 residents. A CPR/First Aide Course was completed on 02/14/2018. A certified staff member will be scheduled on each shift. 2. There are no other residents that have the potential to be affected per an audit of the residents code status. 3. A CPR/First Aid class was held on 02/14/2018. Another class will be held in March, final date to be determined. The CPR/First Aid Certifications will be kept in a binder in the office. A CPR/First Aid Certification Class will be held at least annually, and more often if needed, to ensure one staff person on every shift has CPR/First Aid Certification. 4. The CPR/First Aid Certification	02/20/2018

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	DON indicated she did not know one person was required to be CPR and first aid certified on each shift. She indicated she does not monitor the CPR certificates. She indicated she is not currently CPR certified. Review of the employee list, provided by the Corporate Administrator (CA) on 1/31/18 at 9:40 a.m., indicated the facility had a total of 3 LPN's, 3 QMA's and 10 CNA's currently working at the facility. During an interview on 1/31/18 at 10:27 a.m., the CA indicated prior to today (January 31, 2018), she was unable to find any nursing staff employee who was CPR and first aid certified. On 1/31/18 at 11:05 a.m., the CA indicated they have classes for CPR and first aid scheduled for March 2018. The following employees were not CPR and first aid certified: DON QMA 1 QMA 2 LPN 3 LPN 4 QMA 5 CNA 6 CNA 7 CNA 8 CNA 9 CNA 10 CNA 11 CNA 12 CNA 13 CNA 14 CNA 15.		Binder will be kept in the office. The staffing person, or their designee, will staff at least one staff person on each shift that has CPR/First Aide Certification. The Manager, or their designee, will audit the staffs CPR/First Aid Certifications monthly, for 6 months, then every 3 months for 6 months, then randomly as needed. The Manager, or their designee, will report their findings to the Administrator, or their designee. If there is an issue with compliance the Administrator, or their designee, will investigate the issue and insure the issues are corrected. Completion date 02/20/2018	

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	During an interview on 1/31/18 at 12:59 p.m., the CA indicated the Director of Nursing followed the Indiana State Department of Health (ISDH) guidelines for staffing requirements.			
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 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.			

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	(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 staff completion and documentation of required in-services for 6 of 7 employee files reviewed for completion of dementia training (Administrator, Kitchen Aid 16, QMA 1, Housekeeper 17, Business Office Manager and Certified Dementia Specialist). This deficiency had the potential to affect 8 of 42 residents with a dementia diagnosis. Findings include: On 1/30/18 at 2:20 p.m., the Administrator was asked for provide dementia training from 2017. Review of the employee list, provided by the Corporate Administrator (CA) on 1/31/18 at 9:40 a.m., indicated the facility had a total of 34 employees. Review of the 3 Hour Dementia Training Certificates, provided by the CA on 1/31/18 at 9:40 a.m., indicated the following employees did not have the required 3 hours of dementia training in 2017: Administrator, date of hire 10/6/15 Kitchen Aid 16, date of hire 7/16/15 QMA 1, date of hire 4/17/17 Housekeeper 17, date of hire 3/2/17 Business Office Manager, date of hire 12/26/16 Certified Dementia Specialist, date of hire 7/17/17 During an interview on 1/30/18 at 2:51 p.m., the Administrator indicated they do dementia training twice a year, once in February and maybe again in	R 0120	1.There was no negative out come for any of the 8 residents with a dementia diagnosis. The Administrator has had the initial 6 hr. dementia training and 4.75 hrs. dementia training CEU March 8, 2017. The file folder with the 2017 employee dementia training was found. A Dementia Training 6 hours was been conducted on 02/13/2018 and a 3 hr. Dementia Training was held on 02/012018. All staff members except 3 new hires have received the 6 hr Dementia Training and the annual 3 hr. Dementia training. 2.No other residents have been found with a dementia diagnosis. 3.The Administrator has had the initial 6 hr. dementia training and 4.75 hrs. dementia training CEU March 8, 2017. The file folder with the 2017 employee dementia training was found. A Dementia Training 6 hours was been conducted on 02/13/2018 and a 3 hr. Dementia Training was held on 02/012018. All staff members except 3 new hires have received the 6 hr Dementia Training and the annual 3 hr. Dementia training. The Dementia Training binder will be kept in the office. The Manager, or their designee, will audit the staff Certificates monthly for 6 months, the every 3 months	02/20/2018

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	August. She indicated she was not monitoring the dementia training, but knew they did it twice a year and it "should catch every employee during that year." All the dementia training forms were dated April, 2017. During an interview on 1/31/18 at 12:59 p.m., the CA indicated the Director of Nursing followed the Indiana State Department of Health (ISDH) guidelines for dementia education requirements. This State tag relates to Complaint IN00245359.		for 6 monthly, then as needed. The Manager, or their designee, will report their findings to the Administrator, or their designee. If an issue is found with non-compliance the Administrator, or their designee, will take steps to correct the issue. A Dementia Class will be offered every 3 months to ensure all new staff receive the initial 6 hour class and that current staff receive the 3 hour dementia training annually. 4. The Dementia Training binder will be kept in the office. The Manager, or their designee, will audit the staff Certificates monthly for 6 months, the every 3 months for 6 monthly, then as needed. The Manager, or their designee, will report their findings to the Administrator, or their designee. If an issue is found with non-compliance the Administrator, or their designee, will take steps to correct the issue. A Dementia Class will be offered every 3 months to ensure all new staff receive the initial 6 hour class and that current staff receive the 3 hour dementia training annually. Completion date. 02/20/2018	
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,			

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	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 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 observation, interview and record review, the facility failed to ensure tuberculin skin tests were completed for 6 of 7 employee records reviewed for tuberculin skin tests (CNA 6, CNA 7,	R 0121	1. There was no negative outcome for any of the 42 residents affected. The DON is now aware that all employees must have a TB	02/14/2018

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	CNA 15, Kitchen Aid 18, Kitchen Aid 19, Kitchen Aid 20). Findings include: Review of Employee records began on 1/29/18 at 2:40 p.m. The following noncompliance was found: During an observation on 1/29/18 at 3:38 p.m., the Director of Nursing (DON) was administering a tuberculin test to an employee in her office. The staff person indicated she worked "again" Wednesday night (1/31/18). On 1/29/18 at 3:40 p.m., CNA 15 indicated she was hired in December, but broke her ankle. She indicated she was getting her first tuberculin test today, but had been working prior. She indicated she was not sure how many days she had worked since being hired. Prior to the interview, CNA 15's name was noted to be on the newly hired employee list. During an interview on 1/29/18 at 3:47 p.m., the DON indicated she was not aware that the first tuberculin test had to be read prior to an employee working in the facility. CNA 15's employment record indicated a hire date of 12/4/17. Review of her tuberculin test, indicated it was administered on 1/29/18 at 3:40 p.m. CNA 15's timecard indicated her first day of work was January 8, 2018. CNA 15 has worked the following days without a tuberculin skin test: January 9, 10, 12, 13, 14, 18, 22, 23, 24, 26, 27 and 28, 2017. CNA 15 has worked a total of 103 hours.		mantoux test given and read prior to beginning work and any resident contact. TB Mantoux are to be given and read prior to beginning work or within 1 month prior. 2. There were no other residents in the facility. 3. All new employees must have a TB mantoux test given and read prior to beginning work and any resident contact. TB Mantoux are to be given and read prior to beginning work or within 1 month prior. The DON has been inserviced on the proper procedures. 4.The Manager, or her Designee, will audit all new hires paper work before they begin working to ensure their TB Mantoux test has been given and read before they start work. The Manager, or her designee, will audit all new hires TB Mantoux test every month for 6 months, then she will monitor all new hires TB Mantoux test once every 3 months for 6 months, then as needed. The Manager or her designee, will report any negative findings to the Administrator, or their Designee. The Administrator will take corrective measures as needed.	

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Kitchen Aid 18's employment record indicated a hire date of 1/29/18. Review of the tuberculin test, indicated it was administered on 1/29/18 at 1:30 p.m.

During an interview on 1/29/18 at 3:44 p.m., the DON indicated she gave Kitchen Aid 18 a tuberculin test today around 1:30 p.m. and it was her first day of work.

Kitchen Aid 19's employment record indicated a hire date of 1/2/18. Review of the tuberculin test, indicated it was administered on 1/23/18 at 1:30 p.m.

Kitchen Aid 19's timecard, indicated the first day of work was January 2, 2018. Kitchen Aid 19 has worked the following days without a tuberculin skin test:
January 3, 4, 5, 6, 7, 8, 10, 11, 12, 15, 16, 17, 18, 20, 21, 23, 24, 25, 26 and 29. Kitchen Aid 19 has worked a total of 156 hours.

CNA 6's employee record indicated a hire date of 12/7/17. No tuberculin skin test was provided.

CNA 6's timecard indicated the first day of work was December 16, 2017. CNA 6 has worked the following days without a tuberculin skin test: December 17, 19, 26, 28, 30 and 31. CNA 6 worked a total 57 hours in December. From January 1 through January 28, she has worked a total of 64 hours.

On 1/30/18 at 11:23 a.m., the Corporate Administrator (CA) indicated she could not find a tuberculin test for CNA 6.

Kitchen Aid 20's employment record indicated a hire date of 1/24/18. Review of the tuberculin test,

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	indicated it was administered on 1/29/18 at 4:00 p.m. Kitchen Aid 20's timecard indicated the first day of work was 1/25/18. Kitchen Aid 20 has worked the following days without a tuberculin skin test: January 26, 27, 28 and 29. Kitchen Aid 20 has worked a total of 32 hours. CNA 7's employment record indicated a hire date of 12/7/17. No tuberculin skin test was provided. CNA 7's timecard indicated the first day of work was December 16, 2017. CNA 7 has worked the following days without a tuberculin skin test: December 17, 19, 26, 30 and 31. CNA 7 worked a total 41 hours in December. From January 1 through January 28, she has worked a total of 14.75 hours. On 1/30/18 at 11:23 a.m., the CA indicated she could not find a tuberculin test for CNA 7. Review of a policy titled, "HEALTH SCREENS" received from the Executive Director on 1/31/18 at 11:50 a.m., indicated the following: "It is the policy of this facility to require each employee to complete a health screen prior to resident contact. The screen shall include a TB Skin test, using the Mantoux method (5 TU PPD), UNLESS a previously positive.... Employees will have the TB Skin test at the time of employment, or within one (1) month prior to....If the first step is negative, a second step should be performed 1 to 3 weeks after the first step....The facility shall maintain a health record of each employee...."			

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	01/31/2018

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R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility.			
	Based on observation, interview and record review, the facility failed to ensure residents self-administration of medication assessments were properly implemented for 1 of 3 residents reviewed for self-medication. (Resident B) Findings include: The clinical record for Resident B was reviewed on 1/29/18 at 2:26 p.m. Diagnoses included, but were not limited to, bipolar disorder, dementia, anxiety, cognitive communication deficit and debility. The clinical record lacked an order or assessment for medication self administration. During an interview with Resident B on 1/29/18 at 11:50 a.m., QMA 1 entered the room and brought Resident B a cup with one pill in it. She indicated to Resident B that it was his Tylenol and left the room without watching Resident B swallow the medication. The medication was on the countertop at the completion of the interview.	R 0216	1. There was no negative out come for Resident B. Residents charts will be audited to ensure all residents have the proper documentation for residents self medication. QMA will be inserviced on the proper procedure for passing medication to the residents. 2. There were no other residents identified as being affected by this practice. 3. Residents charts will be audited to ensure all residents have the proper documentation for residents self medication. QMA will be inserviced on the proper procedure for passing medication to the residents. The DON, or her designee, will monitor residents documentation for self medication, 10 charts a month for 6 months. Then 5 charts a month every 3	02/20/2018

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	Review of the unsigned physician order's dated January 2018, Resident B received the following medication at noon: acetaminophen (pain reliever) 500 mg twice daily by mouth. Review of the January Medication Administration Record, QMA 1 indicated the medication had been administered. On 1/29/18 at 12:45 p.m., the Corporate Administrator and Executive Director (ED) were informed QMA 1 came into Resident B's room and left his medication on his counter. The ED indicated she had told them several times before and stated she was really annoyed. She indicated Resident B does not self-medicate and his medications were on the medication cart. Review of a current, undated, facility policy titled "RESIDENT MANAGEMENT AND SELF-ADMINISTRATION OF MEDICATION," provided by the ED on 1/30/18 at 8:40 a.m., indicated the following: "...Residents who are assessed as safe to manage and self-administer their own medications will be permitted to keep their medications in their own apartment/room.		months for 6 months, Then random audits to ensure compliance. 4.The DON, or their designee, will monitor residents documentation for self medication, 10 charts a month for 6 months. Then 5 charts a month every 3 months for 6 months, Then random audits to ensure compliance. She will report her findings to the Manager, or her designee. If there is a non compliance issue the Manager, or their designee, will report the issue to the Administrator, or their designee, for correction. Completed 02/20.2018	
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 obtained and/or documented prior to serving food for 52 out of 121 days reviewed. This deficiency had the potential to affect 42 of 42 residents who received food from the kitchen.	R 0272	1.There were no negative outcomes due to this alleged deficiency. Food temperatures are being taken and documented prior to the serving of food. All food is being served at a safe and appropriate temperatures.	03/06/2018

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	Findings include: Review of the daily food temperature logs from October 2017 through January 2018, the following dates did not not have any food temperatures documented prior to serving: October 1 through October 18, 2017 October 28 through October 30, 2017 November 1 through November 6, 2017 November 13 through November 30, 2017 December 1, 2017 December 6, 2017 December 11 through December 12, 2017 December 19, 2017 December 21, 2017 January 16, 2018 On 1/30/18 at 2:38 p.m., the Dietary Manager indicated she was newly hired in the position this year. She indicated she audits the forms daily to make sure the temperatures were being taken and were correct. Review of an undated facility policy, titled "Policy and Procedures for preventing cross-contamination and temperature abuse in the flow of food through the general food preparation process," which was provided by the Executive Director on 1/31/18 at 9:40 a.m., indicated the following: Procedure: ...3. Record all food temperatures of food in a daily log 4. Always put the thermometer in the thickest part of the food." This State tag relates to Complaint IN00245359.		2. There were no other residents having the potential to be affected. 3. All food will be served at a safe and appropriate temperature. The facility will ensure that food temperatures will be obtained and documented prior to serving food as required. 4. All food will be served at a safe and appropriate temperature. The facility will ensure that food temperatures will be obtained and documented prior to serving food as required. The Executive Chef or their designee, will monitor the food temperature and documentation daily, 5 days a week, for 3 months. Then they will monitor the food temperatures and documentation weekly for 3 months. If any non-compliance issues are found, they will be reported to the Executive Director, or their designee for correction. If the Executive Director, or their designee, cannot correct the issues, they will report their findings to the Administrator, or their designee, for correction. 4. Completion. 03/06/08	