| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | | A. BUILDING 00<br>B. WING | 07/14/2023 |

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| SILVER BIRCH OF KOKOMO | 408 S WASHINGTON STREET<br>KOKOMO, IN 46901 |

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| R 0000<br><br>Bldg. 00 | This survey was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00410800 and IN00411735.<br><br>Complaint IN00410800 - State deficiencies related to the allegations are cited at R0247.<br><br>Complaint IN00411735 - State deficiencies related to the allegations are cited at R0052.<br><br>Survey date: July 11, 12, 13 and 14, 2023<br><br>Facility number: 014137<br><br>Residential census: 118<br><br>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.<br><br>Quality review was completed on July 21, 2023. | R 0000 | Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction for this survey. Please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance by a desk review. Should additional information be necessary to confirm said compliance, please feel free to contact Tony Stewart, Executive Director, Silver Birch of Kokomo. | |
| R 0052<br><br>Bldg. 00 | 410 IAC 16.2-5-1.2(v)(1-6)<br>Residents' Rights - Offense<br>(v) Residents have the right to be free from:<br>(1) sexual abuse;<br>(2) physical abuse;<br>(3) mental abuse;<br>(4) corporal punishment;<br>(5) neglect; and<br>(6) involuntary seclusion.<br>Based on observation, interview and record review, the facility failed to ensure residents were | R 0052 | TAG: R 052 Residents' Rights - Offense | 08/05/2023 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| Tony | stewart | 08/10/2023 |

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| | free from sexual abuse related to a male resident (Resident G) received nude pictures from a facility staff member (Server 10) and two female residents (Resident H and L) were sexually assaulted by a male resident (Resident J) for 3 of 4 residents reviewed for sexual abuse.<br><br>Findings include:<br><br>1. A document, titled "Indiana State Department of Health Survey Report System," indicated at approximately 12:00 p.m., on 6/27/23, Resident G reported to the Culinary Manager he received nude pictures of Server 10 sent to his cellphone, with a text, which indicated "you should text me." The employee was placed on administrative leave during the investigation.<br><br>During an interview, on 7/11/23 at 3:58 p.m., the ED (Executive Director) provided his investigation for the nude pictures being sent by phone from a staff member to a resident. He completed his investigation and concluded Server 10 sent the nude pictures to Resident G from her phone to his, so he terminated her employment with the facility.<br><br>The following information was reviewed in the facility investigation of the nude pictures sent to Resident G.<br>a. A handwritten note had a smiley face with the tongue sticking out, and the note stated, "You should text me!" There was no signature on the note.<br>b. A typed statement from Resident G, dated 6/27/23, indicating at approximately 12:00 p.m., on 6/27/23, he reported to the Culinary Manager he received nude pictures of Server 10 to his cellphone with a text, which indicated "you should text me." Server 10 was placed on administrative leave. | | 1. Corrective actions for affected residents:<br><br>Residents G, H, and L's needs were met by another staff member on 6/25/2023. Termination of the employee who was discovered to have sent the pictures Resident G after the investigation. We have place residents J placed 1 on 1, medication adjustment and we are seeking to placement Resident J in another facility. Residents G, H, and L all feel safe and have no other concerns. Education provided to all staff members on Abuse and Resident Rights. Education provided to all Residents-on-Residents Rights.<br><br>2. 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:<br><br>Interviews with current staff and interviews with residents completed on 7/5/2023 and 8/1/2023 by the Executive Director (ED) and Designee to ensure resident rights are upheld and residents are free from neglect. No additional findings noted.<br><br>3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not | |

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| | c. A document, titled "Investigation Interview Form," dated 6/27/23, indicated Resident G had indicated the incident occurred approximately two weeks prior to this date (6/27/23). Resident G indicated Server 10 grabbed his scrotum and flashed him her breasts. When asked what made him come forward, he indicated Server 10 kept teasing him by showing him pictures of her breasts.<br>d. A document, titled "Investigation Interview Form," dated 6/27/23, indicated Server 10 had indicated the date of the incident was around June 17-22, 2023. She sent Resident G nude pictures of herself. She put a note under his door. She sent the nude pictures to Resident G because he asked her to do it.<br>e. A document, titled "Investigation Interview Form," dated 6/27/23, indicated the Culinary Manager had indicated Resident G asked her to come to his room after the meal. When she went to his room, he handed her a note and showed her some pictures.<br>f. There was a copy of two pictures, which one was of two breasts with nipple piercings and a butterfly tattoo and the other one was the picture of a woman's labia.<br>g. A document, titled "Team Member Progressive Discipline Form," dated 6/28/23, indicated Server 10 was being terminated for misconduct. On 6/27/23, a complaint was raised by Resident G accusing her of inappropriate behavior. He addressed sexually explicit behavior and photographic material. Server 10 did not deny the allegations and indicated the photographs were sent upon Resident G's request. Server 10 was terminated immediately for engaging in inappropriate communications with residents.<br><br>The record for Resident G was reviewed on 7/14/23 at 4:10 p.m. Diagnoses included, but were | | recur:<br><br>All staff were in-serviced on 7/5/2023 and 8/1/2023 by the ED on the abuse policy and resident rights. Current Staff were re-educated on 7/5/2023 and 8/1/2023 by the ED on resident rights and the abuse policy. New employees will be educated on abuse and resident rights during initial orientation. The ED or designee will review resident rights and the abuse policy during the resident council meeting on 7/12/2023.<br><br>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:<br><br>Effective 8/5/2023, the ED or designee will interview 5 residents and interview 3 staff members to ensure resident rights are upheld and residents are free from neglect. The interviews will occur weekly for four weeks, biweekly for four weeks, then monthly for one month. Interviews will be reviewed at monthly QI meeting. The QA Committee will determine if continued interviews are necessary based on 3 consecutive months of compliance. Monitoring will be on-going<br><br>5. By what date the systemic | |

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| | not limited to, major depressive disorder, mild cognitive impairment, chronic pain, and diabetes mellitus type II.<br><br>A care plan addressed the problem Resident G made inappropriate comments and unwanted advances (revised on 12/15/22). He exhibited inappropriate behavior such as disrobing, and verbal abuse or other extreme or erratic behavior patterns (revised on 11/17/22). Interventions included, but were not limited to, 4/22/22, one on one supervision and 9/8/22, received mental health services.<br><br>A care plan addressed the problem Resident G had a problem with cognition and demonstrated inappropriate judgement, behavior, and ability to function in social settings (initiated 8/27/21) and displayed deficits in judgement (initiated 8/27/21).<br><br>A document, titled "Level of Service Assessment/Evaluation-Full List of Items Assisted Living-V5," dated 2/17/23, indicated Resident G's receptive communication indicated he understood information conveyed, but may miss some part or intent of the message. His expressive communication indicated his ability to express himself was limited to making concrete request regarding his basic needs. His judgment indicated he was organized to his daily routine and made safe decisions in familiar situations, but he had trouble in decision making when faced with new tasks or situations. His adaption to change indicated he required reassurance three or more days in a seven-day period. He might have refused to make decisions, might be negative or hostile, and might be passive or withdrawn.<br><br>During an interview, on 7/13/23 at 10:30 a.m., Resident G was observed sitting at his kitchen | | changes will be completed.<br><br>a. Systematic changes will be in effect by 8/5/2023 . The facility respectfully requests a paper compliance review. | |

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| | table in his electric wheelchair. He indicated he received nude pictures from Server 10. He received a note telling him to text the number on the note, so he did. Server 10 explained who she was, but he could not place her face. He asked her to send him a picture, so he would know who he was texting. He was not expecting the kind of pictures she texted him. She tried to get him to meet her after her shift ended at the facility. She wanted to come up to his apartment after she got off work. She was annoying him for one- and one-half weeks trying to get him to let her come to his apartment. He did not think that was the correct thing to do. After she was fired, she sent him the same pictures as she had before with a text message indicating "See what you are missing."<br><br>2. While passing medications with QMA (Qualified Medication Aide) 5, on 7/13/23 at 10:33 a.m., CNA 11 was observed sitting on a bench outside Resident J's room. Resident J came out of his room and was observed talking to CNA 11. QMA 5 indicated she was not here when the incident happened, but she received in report yesterday morning Resident J supposedly cornered Resident L in the third-floor laundry room and kissed her. She did not know any other specifics, but the facility was trying to get him sent out, so he was on one-on-one until he was sent out.<br><br>During an interview, on 7/13/23 at 10:59 a.m., the DON (Director of Nursing) indicated Resident J kissed Resident L, on 7/11/23, in the late evening in the 2nd floor laundry room and she did not want to be kissed by him. The facility had calls out to psychiatric hospitals to get him a room at one of them, but until then he remained on one-on-one supervision. While interviewing the | | | |

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| | DON, the ED (Executive Director) came up to the DON's office. He indicated, at that time, while Resident L was doing her laundry Resident J kissed her in the mouth. He believed she was his girlfriend. He had this behavior one other time back in June 2023, with Resident H. He grabbed her hand and had his hand on her leg and was making inappropriate comments to her. He talked to the resident regarding Resident L, and he admitted to doing it, indicating he was lonely, and he needed love just like everyone else. The police were called out and they told Resident J he was not allowed to touch anyone else in the facility without their permission. He voiced he understood, but the ED did not think he understood, so they were sending him out to a psych hospital.<br><br>During an interview, on 7/13/23 at 11:20 a.m., Resident J indicated he kissed a lady in the mouth after she hugged him. They both were doing their laundry in the third-floor laundry room. She did not tell him she did not want to be kissed. He took another lady's hand awhile back without her permission. His son told him he was not allowed to touch anyone in the facility. He understood now that he was not allowed to touch anyone. Resident J indicated he was lonely, and he only wanted a girlfriend. He was not trying to hurt anyone. The police came to his room and told him he was not allowed to touch anyone.<br><br>a. During an interview, on 7/13/23 at 2:53 p.m., Resident H indicated Resident J followed her to her apartment one day (she could not remember the day or time). She was trying to unlock her door and he was standing behind her and was rubbing his hands in her hair and up and down her back. He took his hands and turned her head sideways and stuck his tongue into her mouth, | | | |

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| | then kissed her on the lips. She told him she was not interested in him and hurried into her apartment. She was afraid of him at that point. She thought he was going to force himself into her apartment and force himself on her. She went outside to the front porch a little later that same day and Resident J came up to her and told her she looked beautiful, and she looked good. He sat down in front of her and was rubbing his hands in her hair and up and down her legs. He had his knee between her knees. She kept pushing her chair back to try to get away from him and he would push his chair closer to her with his knee between hers. She was so terrified she could not scream or even tell him to stop. A female resident (she did not know the resident's name) came out and asked her if she wanted him putting his hands all over her and she could not get a sound to come out. She mouthed the word "No." The female resident told Resident J to get his hands off her and to get away. He had not bothered her since that time, but she avoided him at all costs. She was terrified of him.<br><br>A document, titled "Indiana State Department of Health Survey Report System," indicated on 5/26/23 at 8:30 p.m., Resident H indicated Resident J was trying to hold her hand and rub her back and told her he wanted to marry her.<br><br>A typed statement, dated 5/27/23, from the BOM (Business Office Manager) indicated Resident H had indicated to her Resident J was touching her inappropriately. He was trying to hold her hand, rubbed her back and told her he wanted to marry her, but she did not want to marry him.<br><br>A typed statement, dated 5/27/23, from Resident H indicated Resident J was touching her, trying to hold her hand, trying to kiss her, rubbed her back | | | |

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| | and told her he wanted to marry her. She never told him to stop, but she did tell him she did not want to marry him.<br><br>A typed statement, dated 5/27/23, from Resident J indicated he did hold Resident H's hand, kissed her, and told her he wanted to marry her. He just wanted love and indicated she was his girlfriend.<br><br>A typed statement, dated 5/30/23, indicated Resident H's family was at the facility and wanted to press charges against Resident J because he touched her face and tried to kiss her.<br><br>The record for Resident H was reviewed on 7/14/23 at 3:05 p.m. Diagnoses included, but were not limited to, paranoid schizophrenia, Parkinson's disease, mild cognitive impairment, seizures, and osteoarthritis.<br><br>A progress note, dated 5/26/23 at 7:37 p.m., indicated another resident reported to the DON, Resident H was sitting in the front of the building, when Resident J was sitting next to her feeling her hair, rubbing her shoulders and leg, telling her how beautiful she was, and that he wanted to date her. The resident who reported this incident to the DON told the resident to leave Resident H alone. He got up and left the front porch area of the building. When the DON spoke to Resident H, she indicated "I felt uncomfortable and embarrassed and wanted him to leave."<br><br>b. During an interview, on 7/14/23 at 12:25 p.m., Resident L indicated an incident occurred involving a man who lived in (Room number given), which was Resident J's room number. In the middle of the night (between 2:00 and 3:00 a.m.) on 7/11/23, Resident L went to the third-floor laundry room to do her laundry because the | | | |

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| | second-floor washers were broken down. He was in the laundry room doing his laundry while she was doing her laundry. The whole time he was doing his laundry he was telling her what a beautiful lady she was. He was telling her how lonely he was. He did not smell good, so she was trying to stay away from him. Resident J walked over to the washer and dryers by her. While she was taking her clothes out of the washer and putting them in the dryer, Resident J pushed the back of her head with his hand and turned her head towards his mouth and "French kissed me" (a kiss where the person uses their tongue). He had her cornered in her wheelchair between the washer and the dryer where she could not go anywhere. He was "feeling me up while kissing me." She tried to get out around him as soon as she could. After she got out around him, he invited her back to his apartment, and she told him she was not interested in him. She went back up to her apartment and washed her mouth out with Listerine and brushed her teeth. She went back to the laundry room to get her clothes and prayed he was not still down there when she got there. She got her clothes and took them back to her room to fold them. She felt like she was sexually assaulted by Resident J, and she remained afraid of him because he can walk, and she was confined to a wheelchair. She was not able to get away from him if he tried to attack her again.<br><br>The record for Resident L was reviewed on 7/14/23 at 3:17 p.m. Diagnoses included, but were not limited to, depression, unsteadiness on feet, dependence on renal dialysis, and injury of the perineal nerve at lower left leg.<br><br>A progress note, dated 7/11/23 at 4:50 p.m., indicated Resident H had indicated Resident J came up to her in the laundry room and pushed | | | |

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| | against her and she was unable to push him away. He started to kiss her. She did not give him permission to kiss her. Resident J told her he wanted to be with her, then left the laundry room.<br><br>The record for Resident J was reviewed on 7/14/23 at 3:58 p.m. Diagnoses included, but were not limited to, viral hepatitis, klebsiella pneumoniae, bacteremia, seizures, and urinary tract infection.<br><br>A progress note, dated 7/9/23 at 5:19 p.m., indicated the psychotherapy session notes explored and empathized with triggers of depression including interpersonal problems with other residents.<br><br>A progress note, dated 7/11/23 at 5:00 p.m., indicated the resident displayed inappropriate behavior with Resident L. It was reported Resident J went into the laundry room while Resident L was in there, he pushed against her and started to kiss her without her permission. He indicated her wanted her to be with him. Resident L was able to get around him and leave.<br><br>A progress note, dated 7/11/23 at 5:17 p.m., indicated a statement was received from Resident J regarding the situation in the laundry room with Resident L. He indicated they were "dating." It was explained to Resident J he was not able to touch other residents without their permission. He acknowledged he was aware of that. After the conversation, he went to Resident L's apartment and wanted to talk to her indicating he was in trouble. She did not want to speak to him. A nurse was in Resident L's apartment at that time and Resident J was placed on one-on-one supervision.<br><br>A progress note, dated 7/12/23 at 9:07 a.m., indicated Resident J had inappropriate behavior | | | |

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| | toward Resident L. It was reported he cornered her in the laundry room on the fourth floor and was kissing and touching her. The evening shift nurse spoke with both residents upon report of the behavior. Resident J was placed on one-on-one supervision.<br><br>A current policy, titled "Statement of Resident's Rights," dated 2/8/23 and provided by the ED on 7/11/23 at 1:44 p.m., indicated "...Each resident shall have the right to...Be free from...sexual abuse...."<br><br>A current policy, titled "Abuse and Neglect Prevention," dated 2/8/23 and provided by the ED on 7/11/23 at 1:44 p.m., indicated "Residents of the Premises have the right to be free of abuse...."<br><br>This State tag relates to Complaint IN00411735. | | | |
| R 0092<br><br>Bldg. 00 | 410 IAC 16.2-5-1.3(i)(1-2)<br>Administration and Management - Noncompliance<br>(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:<br>(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 announcement may be used instead of | | | |

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| SILVER BIRCH OF KOKOMO | 408 S WASHINGTON STREET<br>KOKOMO, IN 46901 |

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| | audible alarms.<br>(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.<br>Based on interview and record review, the facility failed to attempt to hold fire and disaster drills in conjunction with the local fire department every six months, failed to hold fire drills once a month, and failed to hold those fire drills on every shift at least once every quarter. This deficiency had the potential to affect 118 of 118 residents who resided in the facility.<br><br>Findings include:<br><br>The facilities fire drills were reviewed on 7/12/23 at 4:15 p.m.<br>1. There were no fire and disaster drills held in conjunction with the local fire department every six months.<br>2. There was no fire drill completed in January 2023.<br>3. There were three fire drills completed on the day shift, five completed on the evening shift and two completed on the night shift.<br><br>During an interview, on 7/13/23 at 10:50 a.m., the Maintenance Director indicated there were no fire and disaster drills held in conjunction with the local fire department every six months. He was not here in January 2023, but he was unable to find a fire drill for that month. A fire drill was not completed on at least every shift on every quarter. | R 0092 | TAG: R 092 Administration and Management – Noncompliance<br>1. Corrective actions for affected residents:<br>Fire department was contacted by phone on 7-21-2023 and by email on 8-4-2023 to participate with next scheduled fire drill on the week of Aug. 21, 2023.<br>2. Methods for identification of other potentially affected residents.<br>The facility identified that all residents have the potential to be affected by deficient practice by the facility not having the fire department participate in fire drills at least two times per year, or at least once every six months. No residents were found to be affected at this time.<br>3. Measures to prevent recurrence:<br>On 7/18/2023 Executive Director has requested semi -annual local fire departments participation with our monthly fire drills. The fire dept will sign our monthly fire drill form twice a year no more than six months apart. During the 2023 calendar year Maintenance Director and/or designee will audit the facility's fire drills monthly | 08/05/2023 |

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| | | | using audit form tool for 5 months ending Dec. 2023<br>4. Corrective actions monitoring: The corrective actions will be monitored monthly using the facility's monthly fire drill audit form to be completed monthly for 12 months ending in Dec 2023. The Maintenance Director and/or designee Will complete this monthly audit. Compliance completion date.<br>5. The systemic changes will be completed.<br>a. Systematic changes will be in effect by 8/5/2023. The facility respectfully requests a paper compliance review. | |
| R 0247<br><br>Bldg. 00 | 410 IAC 16.2-5-4(e)(7)<br>Health Services - Deficiency<br>(7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident.<br>Based on observation, interview and record review, the facility failed to follow physician's orders and administer a resident her pain medication as ordered for 1 of 3 residents reviewed for medication errors. (Resident M)<br><br>Finding includes:<br><br>During a medication setup for administration, on 7/11/23 at 4:00 p.m., Resident M came up to QMA 9's medication cart very upset indicating she had not had her Tramadol (a non-narcotic pain medication) since the night before, which was on | R 0247 | TAG: R 247 Health Services – Deficiency<br><br>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br><br>Resident M medication record was audited. The Wellness Nurse or Designee to ensure medication error is entered in the resident's record and notify the resident's | 08/05/2023 |

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| | 7/9/23, prior to going to bed. The medication ran out and none of the other nursing staff knew where anymore pills were located.<br><br>Resident M's record was reviewed on 7/14/23 at 3:55 p.m. Diagnoses included, but were not limited to, chronic pain, generalized anxiety disorder, mild cognitive impairment, dementia, and anemia.<br><br>An EMAR (Electronic Medication Administration Record) included, but was not limited to, the following medication:<br>6/21/23, Tramadol 50 mg (milligrams). Take one tablet by mouth three times daily at 8 a.m., 2 a.m., and 8 p.m. for chronic pain. For the dates of 7/10 and 7/11, there were three (3) times on 7/10 and two (2) times on 7/11, Resident M did not receive her Tramadol. The code indicated was 11. The code chart on the EMAR indicated 11 meant the medication was not available.<br><br>During an interview, on 7/11/23 at 4:42 p.m., with the DON (Director of Nursing) in attendance, QMA 9 indicated the medication cycle fill ended on 7/9/23, and the new medication cycle fill began on 7/10/23. The resident did not get any Tramadol in her dose packets because she must have needed a new script. If a new script was needed for a controlled substance, then the first fill would be sent out on a bubble card and the bubble card would be locked up in the narcotic drawer on the cart. Her narcotic card must be in the back up narcotic drawer.<br><br>QMA 9 went to the second floor to look in the backup cart to see if the medication was stored in the overflow narcotic drawer and she found a bubble card for Resident M's tramadol in the overflow narcotic drawer. QMA 9 indicated her Tramadol was a scheduled medication for three | | physician where there are any actual or potential detrimental effects to the resident.<br><br>2. 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<br><br>The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice.<br><br>3. What measures will be put into place or what systemic changes has the facility will make to ensure that the deficient practice dose not recure:<br><br>All QMA and Nurses Staff will be in-serviced on proper medication administration and documentation.<br><br>4. How the corrective action will be monitored to ensure the deficient practice will not recure, what quality assurance program will be put into place:<br><br>The Wellness Director or designee will review the MARS and make sure the overflow is checked for the next 3 months to ensure medications are being administered as prescribed and are properly documented. The Wellness Director or designee | |

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| | times a day at 8 a.m., 2 p.m., and 8 p.m., so she would not be able to have a dose of the medication until her 8:00 p.m., dose tonight.<br><br>A current policy, titled "Medication Administration Program Policy," dated with a revision date of 3/24/21 and provided by the DON on 7/14/23 at 1:00 p.m., indicated "...3. Residents receiving medication assistance will have...Documentation of the medication name, dose, time taken by resident...5. Documentation in the medication record is complete and accurate. a. Resident receives medications as prescribed...d. Medication is available to the resident in a correct and timely manner...."<br><br>This State tag relates to Complaint IN00410800. | | shall audit med availability The QA tool will be utilized Daily times a week x4 weeks, then weekly x 4 weeks, then monthly for 3 months, then quarterly thereafter. All finding will be sent to QA committee to correct.<br><br>5. By what date the systemic changes will be completed.<br><br>a. Systematic changes will be in effect by 8/5/2023 . The facility respectfully requests a paper compliance review. | |
| R 0273<br><br>Bldg. 00 | 410 IAC 16.2-5-5.1(f)<br>Food and Nutritional Services - Deficiency<br>(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.<br>Based on observation, interview and record review, the facility failed to follow proper sanitation procedures for air drying metal pans, changing the oil in the deep fryer, and the facility failed to ensure the walk-in freezer stayed at a safe temperature to keep the food frozen. This had the potential to affect 118 of 118 residents receiving food from the kitchen.<br><br>Findings include:<br><br>During the kitchen tour, on 7/14/23 at 11:17 a.m., the Culinary Manager was in attendance and the following items were observed:<br>1. There were metal pans with beads of clear liquid | R 0273 | TAG: R 273) Food and Nutritional Services - Deficiency<br><br>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br><br>No residents were found to have been affected by the deficient practice.<br><br>2. How the facility will identify other residents having the potential to be affected by the | 08/05/2023 |

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| | between them. At that time, the Culinary Manager indicated the liquid between the pans was water and it should not be there. Water between the pans meant the staff did not let the pans air dry prior to stacking them.<br>5-One-half cake pans<br>2-One-half pans<br>7-One-half deep pans<br>3-Deep pans<br><br>2. The deep fryer oil was a deep brown with pieces of debris in it. The bottom of the fryer could not be seen. There was no reflection of the baskets in the oil. Cook 7 indicated at that time the fryer oil had not been changed in 2 weeks' time. Oil had been ordered, but it would not be here until 7/17/23.<br><br>3. The walk-in freezer temperature was 15 degrees F (Fahrenheit).<br>The blue bunny ice cream in the 4 oz cup was completely softened.<br>The mixed vegetables were separated in the bag instead of frozen in clumps.<br>The temperatures for the walk-in freezer for July 2023 ranged from 7 degrees F to 18 degrees F.<br><br>During an interview, at that time, the Culinary Manager indicated she had been working in the freezer making meals for employees one- and one-half hours ago. She worked on those meals for 33 minutes with the freezer door open. She indicated the temperature had been above 0 degrees F all month, but she did not think anything about it, since the temperatures had been running around the same every day and the foods had been frozen.<br><br>A current policy, titled "Food Storage," dated 1/20/2020 and provided by the Culinary Manager | | same deficient practice and what corrective action will be taken<br><br>An audit was conducted by Culinary Manager to ensure that all food had been properly labeled and dated and all walk-in coolers and freezers have the correct temps. Audit will be done to check the deep fryer oil. Audit will be done to make sure the pots and pans are dried correctly. No other items were found to be affected by this deficient practice.<br><br>3. What measures will be put into place or what systemic changes has the facility will make to ensure that the deficient practice dose not recure:<br><br>All walk-in cooler and freezer will be checked daily for correct temps. All pots and pans will be checked daily to make sure they are drying correctly. The deep fryer oil will be checked daily and changed when needed. All Culinary staff will be in-serviced on the food storage, dishwashing sanitation and Fryer cleaning.<br><br>4. How the corrective action will be monitored to ensure the deficient practice will not recure, what quality assurance program will be put into place:<br><br>QA/Audit tool has been developed and will be implemented to ensure | |

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| | on 7/14/23 at 1:44 p.m., indicated "...Refrigerator/Freezer and Temperatures...Freezer temp-0 For below/frozen food solid...."<br><br>A current policy, titled "Fryer Cleaning Instructions," undated and provided by the Culinary Manager on 7/14/23 at 1:44 p.m., indicated "Fryer Cleaning instructions: Fryer is to be cleaned Every other week or as needed with steps and instruction below...."<br><br>A current policy, titled "Residential Care Kitchen/Food Service Observation," dated April 2021 and provided by the Culinary Manager on 7/14/23 at 1:44 p.m., indicated "...No moisture present between stacked plates, pots, pans, or utensils...Freezer temperature 0 degrees F or below...." | | correct Food storage, dishwashing sanitation, and deep fryer cleaning.<br><br>The QA tool will be utilized Daily times a week x4 weeks, then weekly x 4 weeks, then monthly for 3 months, then quarterly thereafter. All finding will be sent to QA committee to correct.<br><br>5. By what date the systemic changes will be completed.<br><br>a. Systematic changes will be in effect by 8/5/2023 . The facility respectfully requests a paper compliance review. | |