STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155475	A. BUILDING 00 B. WING	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TOWNE HOUSE RETIREMENT COMMUNITY	2209 ST JOE CENTER RD FORT WAYNE, IN 46825

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey and a Non-Certified Comprehensive Licensure Survey. This visit included a Nurse Aid Training Review. Survey dates: May 28, 29 and 30, 2024. Facility number: 000541 Provider number: 155475 AIM number: N/A Census Bed Type: SNF: 12 Residential: 208 NCC: 40 Total: 260 Census Payor Type: Medicare: 12 Private: 248 Total: 260 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 31, 2024.	F 0000	Submission of this plan of correction shall not constitute or be construed as an admission that Towne House Retirement Community provides anything other than a high quality of care to its residents. The Towne House considers itself to be a partner with the Indiana State Department of Health and other entities in an ongoing effort to continually improve the services provided in senior living. We believe that any feedback provided to us should be taken very seriously, and we are committed to using our resources to make any adjustments necessary to achieve better outcomes for residents. As required, the facility submits the following plan of correction: The Towne House is requesting a desk review of the plans of corrections submitted.	
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Hayley Carr	Executive Director	06/18/2024

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	to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.	F 0655	This deficiency was cited due to	06/27/2024

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	Based on interview and record review, the facility failed to ensure a person-centered, individualized Baseline Care Plan was developed with instructions needed to provide effective care for 1 of 1 resident reviewed with a catherter. (Resident 116) Findings include: Resident 116's record was reviewed on 5/28/24 at 2:35 PM. Diagnoses included an open reduction internal fixation (surgery to repair) of a fracture to the left femur, coronary artery disease, atrial fibrillation, (irregular heartbeat) anemia due to chronic blood loss, enlarged prostate gland and urinary retention. A physician order dated 5/20/24 indicated Resident 116 was to be administered acetaminophen (pain reliever) every 6 hours as needed for a pain rating of 1 to 5 on a 1 to 10 scale. A physician order dated 5/20/24 indicated Resident 116 was to be administered oxycodone (narcotic pain reliever) every 6 hours as needed for a pain rating of 6 to 10 on a 1 to 10 scale. A physician order dated 5/20/24 indicated Resident 116 was to be administered cyclobenzaprine (muscle relaxer) every 12 hours as needed for muscle spasms. A physician order dated 5/20/24 indicated Resident 116 was to be administered nitroglycerin every 5 minutes as needed for chest pain for a maximum of 3 doses. A physician order dated 5/20/24 indicated Resident 116 was to be administered apixaban		one resident's baseline care plan not being person-centered and individualized with instructions needed to provide effective care. Resident 116's care plan was updated. No adverse effects to this resident. An admission audit has been completed on all current residents on the unit to validate care plans have been completed and are accurate. No other residents were affected. An in-service was held on 6/11/2024 and the interdisciplinary team was educated on the Care Plan Policy. To ensure compliance, the MDS Coordinator will audit baseline care plans on a weekly basis for 3 months and then monthly for 3 months. If 100% compliance is not achieved within 6 months, the QAPI committee will recommend additional compliance strategies. This information will be reviewed by the Executive Director and included in our QAPI committee meetings with our next meeting scheduled for 7/16/2024 and quarterly thereafter for a one-year period. For paper compliance request, please refer to the attached documents: Care Plan Policy and Care Plan Audit forms. Plan of correction will be completed by June 27, 2024.	

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	(blood thinner) twice daily for atrial fibrillation. Resident 116's Baseline Care Plan dated 5/20/24 indicated Resident 116's Brief Interview for Mental Status (BIMS) score was 15 (cognitively intact), had an indwelling urinary catheter in place to drain urine, had been prescribed narcotic pain medications, anticoagulants, (blood thinner) and diuretics (water pill), and had post-surgical pain to their left hip. There was no documentation in the Baseline Care Plan section to evaluate pain on a 1 to 10 scale. The Baseline Care Plan did not indicate Resident 116 had skin issues. There was no documentation in the Baseline Care Plan's skin integrity section. A physician order dated 5/21/24 indicated Resident 116 was to have the indwelling urinary catheter removed. A physician order dated 5/21/24 indicated Resident 116 was to have a straight catheter procedure performed (urinary catheter inserted into the bladder and removed immediately after the release of urine) every 8 hours as needed for urinary retention. Resident 116's Care Plan focus dated 5/22/24 indicated the resident was at risk for infection. The target goal was to be free from signs and symptoms of infection through 8/18/24. Interventions included antibiotics, infection prevention education, standard precautions, encourage fluids and evaluation of wounds. The Care Plan was not individualized to Resident 116's infection risks related to their surgical incision or the straight catheter procedure. Resident 116's Care Plan focus dated 5/22/24 indicated the resident was on a regular diet and			

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	had a surgical skin impairment to the left hip. The target goal was to maintain adequate nutritional status through 8/18/24. Interventions included medications, observing for malnutrition, monitoring weight, serving diet as ordered, monitoring and recording intake at every meal. The Care Plan dated 5/22/24 did not include a focus, a target goal or interventions for the following care concerns: 1. unusual bleeding 2. chest pain 3. urinary retention 4. diuretic use 5. urinary drainage via straight catheter 6. infection risk from straight catheter 7. muscle spasms 8. surgical incision care 9. infection risk from surgical incision 10. pain assessment 11. effects of narcotic pain medication. In an interview on 5/29/24 at 3:02 PM, the Executive Director (ED) indicated the facility had completed Resident 116's Baseline Care Plan within 24 hours as required. The ED indicated the facility had 21 days after a resident's admission to complete an official Care Plan. The ED reviewed the Baseline Care Plan and the current Care Plan. The ED indicated neither the Baseline Care Plan, nor the current Care Plan were individualized to Resident 116. In an interview on 5/29/24 at 4:09 PM the Director of Nursing (DON) reviewed Resident 116's Baseline Care Plan and current Care Plan. The DON indicated neither the Baseline Care Plan, nor the current Care Plan were individualized to Resident 116. The DON indicated Resident 116's Baseline Care Plan did not include a pain scale rating or a surgical incision, straight catheter			

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	procedure or their specific infection risk. The DON indicated neither the Baseline nor current Care Plan included the minimum healthcare information necessary to provide individualized care to Resident 116. A current facility policy dated 4/06 and revised 10/19 provided by the DON on 5/30/24 at 12:20 PM indicated the care plan is a compilation of services to be furnished to each resident with the goal to reach or maintain the resident's highest possible physical, mental, and psychosocial well-being. The policy indicated an individualized plan of care would be initiated upon admission. The policy indicated the individualized care plan would identify each resident's needs related to health, disease, condition, impairments, physical function, mental status, nutrition, psychosocial health, safety, and discharge potential. The policy indicated modifications and additions to the care plan would be updated as the resident's needs changed. The policy indicated the resident's individualized care plan would be continual, reviewed quarterly or as needed.			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure physician orders were current for	F 0684	This deficiency was cited due to a physician order not being current for the provision of wound care to a	06/27/2024

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	the provision of wound care to a surgical incision for 1 of 1 resident reviewed (Resident 116). Findings include: Resident 116's record was reviewed on 5/28/24 at 2:35 PM. Diagnoses included an open reduction internal fixation (surgery to repair) of a fracture to the left femur. Resident 116's Baseline Care Plan dated 5/20/24 indicated Resident 116's Brief Interview for Mental Status (BIMS) score was 15 (cognitively intact). Resident 116's Baseline Care Plan dated 5/20/24 did not indicate Resident 116 had skin issues. There was no documentation in the Baseline Care Plan skin integrity section. Resident 116's current, completed, and discontinued physician orders dated 5/20/24 through 5/29/24 did not include wound care instructions for the surgical incision of their left hip. Resident 116's current Care Plan dated 5/22/24 did not include a focus, a target goal, or interventions for wound care to the resident's left hip surgical incision. A hospital Discharge Summary dated 5/20/24 at 11:19 AM indicated Resident 116's left hip surgical incision's dressing was to be reinforced or changed daily as needed. The surgical incision was to be assessed for complications daily. The staples were to be removed in 2 weeks. A Skin and Wound Evaluation dated 5/21/24 at 10:51 AM indicated Resident 116 had a surgical wound to the front of their left thigh. The wound		surgical incision for one resident. A physician order was entered for Resident 116 on 5/28/24. Resident 116 has since successfully discharged home from rehab. No adverse effects noted. A physician order wound care audit has been completed and no other residents on the unit were affected. An in-service was held on 6/11/2024 and the interdisciplinary team and administrative nursing staff were educated on the Dressing Change Policy. To ensure compliance, the wound care nurse will audit physician orders and wound care on a weekly basis for 3 months and then monthly for 3 months. If 100% compliance is not achieved within 6 months, the QAPI committee will recommend additional compliance strategies. This information will be reviewed by the Executive Director and included in our QAPI committee meetings with our next meeting scheduled for 7/16/2024 and quarterly thereafter for a one-year period. For paper compliance request, please refer to the attached documents: Clean Dressing Change Policy and Wound Care Audit forms. Plan of correction will be completed by June 27, 2024.	

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	was present on admission to the facility on 5/20/24. The wound was 1.7 centimeters (cm) long and 0.4 cm wide. The wound had 3 staples. The dressing was intact. A Skin and Wound Evaluation dated 5/21/24 at 10:52 AM indicated Resident 116 had a surgical wound to the left side of their left thigh. The wound was present on admission to the facility on 5/20/24. The wound was 2.7 cm long and 0.4 cm wide. The wound had 4 staples. The dressing was intact. A Skin and Wound Evaluation dated 5/21/24 at 10:54 AM indicated Resident 116 had a surgical wound to the front of their left hip. The wound was present on admission to the facility on 5/20/24. The wound was 3.8 cm long and 0.5 cm wide. The wound had 6 staples. The wound dressing was intact. A progress note dated 5/21/24 at 2:34 PM indicated Resident 116's surgical sites had been evaluated. The staples were intact and healing well. A progress note dated 5/21/24 at 5:25 PM indicated Resident 116 had experienced a fall in their room. A progress note dated 5/22/24 at 11:52 AM indicated Resident 116 had increased bruising and swelling around their surgical incision. The dressing had been saturated with bloody drainage. A Skin and Wound Evaluation dated 5/28/24 at 7:48 AM indicated Resident 116 had a surgical wound to the left side of their left thigh. The wound was present on admission to the facility on			

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	5/20/24. The wound was 2.3 cm long and 0.3 cm wide. The wound had 4 staples. The staples were removed by the Nurse Practitioner. The wound did not have a dressing. A Skin and Wound Evaluation dated 5/28/24 at 7:49 AM indicated Resident 116 had a surgical wound to the front of their left thigh. The wound was present on admission to the facility on 5/20/24. The wound was 1.4 cm long and 0.2 cm wide. The wound had 3 staples. The staples were removed by the Nurse Practitioner. A Skin and Wound Evaluation dated 5/28/24 at 7:50 AM indicated Resident 116 had a surgical wound to the front of their left hip. The wound was present on admission to the facility on 5/20/24. The wound was 3.5 cm long and 0.4 cm wide. The wound had 6 staples. The dressing was intact. The wound was cleansed with soap and water. The staples were removed by the Nurse Practitioner. A Nurse Practitioner progress note dated 5/28/24 at 9:45 AM indicated Resident 116 had experienced a fall in their room on 5/21/24 that caused bleeding from their upper most hip incision. The staples were removed. Adhesive strips (steri-strips) were applied to the upper most incision and the middle incision. In an interview on 5/30/24 at 12:25 PM the Director of Nursing (DON) indicated hospital discharge surgical incision care instructions should have been included on Resident 116's physician orders upon admission to the facility. A current facility policy dated 2/06 and revised 3/24 provided by the DON on 5/30/24 at 12:53 PM indicated physician orders for dressing changes			

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	would be verified to ensure dressing changes followed state regulations, federal regulations, and national guidelines. 3.1-37			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review the facility failed to ensure safe transfer assistance for 1 of 5 residents reviewed (Resident 115). Findings include: During an interview on 5/28/24, a family member of Resident 115 indicated he was concerned Resident 115 had a fall while transferring in the middle of the night the previous weekend, resulting in a skin tear to her arm, bruising and pain. He indicated her pain resulted in a setback in her progress in therapy. He indicated only one staff member was assisting her at the time of the fall. During an interview on 5/30/24 at 1:40 PM, Resident 115 indicated she was transferring from her bed to her wheelchair when one of her feet caught on the other causing her to lose her balance and fall backward to her buttocks, tearing	F 0689	This deficiency was cited due to an unsafe transfer for one resident. Resident 115 progressed in therapy and successfully discharged home from rehab. A fall audit has been completed and no other residents on the unit were affected. An in-service was held on 6/11/2024 and the interdisciplinary team was educated on the Fall policy. The nurse involved with the transfer was educated on the Fall Policy and safe transfers. To ensure compliance, the Director of Nursing will audit falls, which includes observation of safe transfers, on a weekly basis for 3 months and then monthly for 3 months. If 100% compliance is not achieved within 6 months, the QAPI committee will recommend	06/27/2024

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	the skin on her elbow on the table as she fell. She indicated only one staff member was in the room at the time of the transfer. Resident 115's record was reviewed on 5/28/24 at 12:28 PM. Diagnoses included displaced intertrochanteric fracture of the left femur, subsequent encounter for closed fracture with routine healing, muscle weakness, generalized, and unsteadiness on feet. Resident 115's current admission Minimum Data Set (MDS), dated 5/20/24, indicated her Basic Interview for Mental Status (BIMS) score was 14 (cognitively intact). The MDS indicated the resident was dependent for transfers from a bed to a chair. Progress notes dated 5/25/24 at 4:42 AM indicated a staff member was assisting Resident 115 to transfer from her bed to a wheelchair when her leg gave out. Resident 115 sustained a skin tear on her left elbow from the table as she tried to stop the fall. Resident 115's current care plan regarding limited physical mobility, dated 5/17/24, indicated the resident had a problem of limited mobility related to weakness, recent left femur surgery and pain with a goal date of 8/4/24. Interventions included referring to the green therapy binder for current assistance needs. An instructional document in the green therapy binder dated 5/17/24 and last updated 5/24/24, provided by Licensed Practical Nurse 10 indicated Resident 115 required maximum assistance of two staff for transfers. In an interview on 5/30/24 at 12:37 PM, the		additional compliance strategies. This information will be reviewed by the Executive Director and included in our QAPI committee meetings with our next meeting scheduled for 7/16/2024 and quarterly thereafter for a one-year period. For paper compliance request, please refer to the attached documents: Fall Policy and Fall Audit forms. Plan of correction will be completed by June 27, 2024.	

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	Director of Nursing (DON) indicated one staff member was assisting Resident 115 at the time of her fall on 5/25/24. She indicated two staff should have been assisting with the transfer. In an interview on 5/30/24 at 12:46 PM, Physical Therapist 11 and Physical Therapy Assistant 12 indicated Resident 115 had not been cleared at any time to transfer with one assist since her admission to the facility. A current policy titled General Policy- Falls Policy, last revised 7/22 provided by the DON indicated the facility should implement appropriate measures to ensure safety. 3.1-45(a)(2)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and			

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	serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review the facility failed to ensure kitchen sanitation was maintained, opened food items were labeled and dated in the kitchen. 12 of 12 residents residing in the facility consumed food prepared in the kitchen. Findings include: 1. During an observation and interview in the main kitchen on 5/28/24 at 9:20 AM, a package of cheese slices and two packets of cheese cubes were observed with no label or date visible on the package on a shelf in the walk-in cooler. The Dietary Manager (DM indicated the packages should have been labeled and dated when opened. A container of ground beef with an expiration date of 5/23 and a container of diced tomatoes with an expiration date of 5/20 were observed on the shelf in the walk-in cooler. The DM indicated the ground beef was expired and should have been discarded. Multicolored specks of debris, too many to count, a dry piece of pepperoni, and several dime-sized red, dried spots near the container labeled marinara sauce were observed on the work surface area on the front of the pizza station. A container of cut up peppers was not covered with a lid or label. The DM indicated the pizza station had not been used yet that day and should have been cleaned after each use. In the reach in cooler, a bag of cut up lettuce, undated, had yellowish liquid visible at the bottom of the package. The DM indicated it should be discarded. The reach in cooler also had a tray of cups of salsa, ketchup, sour cream, poppy seed dressing, and horseradish dated 5/17 and 5/20. The DM indicated the cups should be	F 0812	This deficiency was cited due to failure to ensure kitchen sanitation was maintained and opened food items were labeled and dated in the kitchen. No residents were adversely affected. The kitchens have been audited several times since 5/28/24 to ensure compliance. Dining staff members are being educated and retrained on the Sanitation and Infection/Control Policy, Using Chemicals to Sanitize Food Contact Services Policy, Production, Purchasing, Storage Policy, Refrigerated, Freezer, and Dry Storage Life of Food Policies. All items entering the building shall have the received date and first in, first out (FIFO) must be followed. Any unopened items removed from the manufacturer's original packaging will be individually labeled. For all open package items, employees must tightly wrap, label and date the item with the appropriate dating label. Items are to be discarded per the Production, Purchasing, Storage Policy. Dining staff were educated to keep work areas clean after each use. The sanitizer buckets are to be between 200 - 400ppm per the Using Chemicals to Sanitize Food Contact Surfaces Policy. The dining director placed test	06/27/2024

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	155475	A. BUILDING 00 B. WING	05/30/2024

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	discarded. In an observation and interview on 5/28/24 at 9:44 AM, the Executive Chef used a test strip to test a bucket of sanitizer water being used to clean work surfaces in the kitchen. He indicated the solution tested at about 150 parts per million (ppm) of QUAT solution. He indicated the solution should test between 200 and 400 ppm to be considered effective for sanitation purposes. He emptied the bucket, prepared a new supply of sanitizer water and conducted another test. He indicated the test also resulted in about 150 ppm and he intended to call a service person in to adjust the calibration of the sanitizer dispenser. 2. In an observation and interview in the Health Center kitchen on 5/28/24 at 9:53 AM, the Executive Chef indicated he could not locate the test strips for sanitizer solution. A current policy title Production, Purchasing, Storage, last revised 1/22 provided by the DM on 5/28/24 at 11:05 AM indicated all unused portions and open packages should be covered, labeled, and dated and food past the expiration date should be discarded. The policy indicated sanitizer test strips should be readily available wherever sanitizer is dispensed. 3.1-21(i)(2) 3.1-21(i)(3)		strips for the sanitizer solution in the storage compartment in the Health Center Kitchen at the time the deficiency was noted. To ensure compliance, dining managers will audit all food storage areas and sanitation on a weekly basis for 3 months and then monthly for 3 months. If 100% compliance is not achieved within 6 months, the QAPI committee will recommend additional compliance strategies. This information will be reviewed by the Executive Director and included in our QAPI committee meetings with our next meeting scheduled for 7/16/2024 and quarterly thereafter for a one-year period. For paper compliance request, please refer to the attached documents: Sanitation and Infection/Control Policy, Using Chemicals to Sanitize Food Contact Services Policy, Production, Purchasing, Storage Policy, Refrigerated, Freezer, and Dry Storage Life of Food Policies, Food Storage Audit and Sanitation Audit forms. Plan of correction will be completed by June 27, 2024.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit included a Non-Certified	R 0000	Submission of this plan of correction shall not constitute or be construed as an admission that Towne House Retirement	

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	Comprehensive Licensure Survey. This visit also included a Nurse Aid Training Review. Survey dates: May 28, 29 and 30, 2024. Facility number: 000541 Residential Census: 208 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed May 31, 2024		Community provides anything other than a high quality of care to its residents. The Towne House considers itself to be a partner with the Indiana State Department of Health and other entities in an ongoing effort to continually improve the services provided in senior living. We believe that any feedback provided to us should be taken very seriously, and we are committed to using our resources to make any adjustments necessary to achieve better outcomes for residents. As required, the facility submits the following plan of correction: The Towne House is requesting a desk review of the plans of corrections submitted.	
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 kitchen sanitation was maintained, opened food items were labeled and dated in the kitchen. 208 of 208 residents residing in the facility consumed food prepared in the kitchen. Findings include: 1. During an observation and interview in the Retirement Center kitchen on 5/28/24 at 9:20 AM,	R 0273	This deficiency was cited due to failure to ensure kitchen sanitation was maintained and opened food items were labeled and dated in the kitchen. No residents were adversely affected. The kitchens have been audited several times since 5/28/24 to ensure compliance. Dining staff members are being educated and retrained on the Sanitation and Infection/Control	06/27/2024

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	a package of cheese slices and two packets of cheese cubes were observed with no label or date visible on the package on a shelf in the walk-in cooler. The Dietary Manager (DM indicated the packages should have been labeled and dated when opened. A container of ground beef with an expiration date of 5/23 and a container of diced tomatoes with an expiration date of 5/20 were observed on the shelf in the walk-in cooler. The DM indicated the ground beef was expired and should have been discarded. Multicolored specks of debris, too many to count, a dry piece of pepperoni, and several dime-sized red, dried spots near the container labeled marinara sauce were observed on the work surface area on the front of the pizza station. A container of cut up peppers was not covered with a lid or label. The DM indicated the pizza station had not been used yet that day and should have been cleaned after each use. In a reach in cooler, a bag of cut up lettuce, undated, had yellowish liquid visible at the bottom of the package. The DM indicated it should be discarded. The reach in cooler also had a tray of cups of salsa, ketchup, sour cream, poppy seed dressing, and horseradish dated 5/17 and 5/20. The DM indicated the cups should be discarded. 2. In an observation and interview on 5/28/24 at 9:44 AM, the Executive Chef used a test strip to test a bucket of sanitizer water being used to clean work surfaces in the kitchen. He indicated the solution tested at about 150 parts per million (ppm) of J-512 solution. He indicated the solution should test between 200 and 400 ppm to be considered effective for sanitation purposes. He emptied the bucket and prepared a new supply of sanitizer water and conducted another test. He indicated the test also resulted in about 150 ppm and he intended to call a service person in to		Policy, Using Chemicals to Sanitize Food Contact Services Policy, Production, Purchasing, Storage Policy, Refrigerated, Freezer, and Dry Storage Life of Food Policies. All items entering the building shall have the received date and first in, first out (FIFO) must be followed. Any unopened items removed from the manufacturer's original packaging will be individually labeled. For all open package items, employees must tightly wrap, label and date the item with the appropriate dating label. Items are to be discarded per the Production, Purchasing, Storage Policy. Dining staff were educated to keep work areas clean after each use. The sanitizer buckets are to be between 200 - 400ppm per the Using Chemicals to Sanitize Food Contact Surfaces Policy. To ensure compliance, dining managers will audit all food storage areas and sanitation on a weekly basis for 3 months and then monthly for 3 months. If 100% compliance is not achieved within 6 months, the QAPI committee will recommend additional compliance strategies. This information will be reviewed by the Executive Director and included in our QAPI committee meetings with our next meeting scheduled for 7/16/2024 and quarterly thereafter for a one-year	

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	adjust the calibration of the sanitizer dispenser. A current policy titled Production, Purchasing, Storage, last revised 1/22 provided by the DM on 5/28/24 at 11:05 AM indicated all unused portions and open packages should be covered, labeled, and dated and food past the expiration date should be discarded. A current policy titled Sanitation and Infection Prevention/Control, last revised 1/19, provided by the DM on 5/28/24 at 12:44 AM, indicated sanitizer solution should test at 200ppm to 400 ppm for J-512 sanitizer.		period. For paper compliance request, please refer to the attached documents: Sanitation and Infection/Control Policy, Using Chemicals to Sanitize Food Contact Services Policy, Production, Purchasing, Storage Policy, Refrigerated, Freezer, and Dry Storage Life of Food Policies, Food Storage Audit and Sanitation Audit forms. Plan of correction will be completed by June 27, 2024.	