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	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRANKLIN SENIOR LIVING LLC	1375 NICOLE DRIVE FRANKLIN, IN 46131

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R 0000 Bldg. 00	This visit was for an Initial State Residential Licensure Survey. Survey dates: December 20 and 21, 2022 Facility number: 015132 Residential Census: 5 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed December 27, 2022.	R 0000		
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Anjela D. Sullivan	Executive Direcor	01/12/2023

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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	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 conduct fire drills to prepare staff for an emergency as indicated by facility policy. Findings include: During a review of the facilities Fire Drill records, the Executive Director (ED) provided a form that was to be used to conduct the fire drills. The ED indicated it was the current form being used for fire drills. The following information was to be documented on the form for each fire drill. Location of fire: Type of fire and or conditions simulated: Weather at time of drill: Was the alarm activated?: How was the alarm activated?: Did fire department direct drill?: Did Staff respond to fire? Were exits monitored by staff? Problems and or obstruction encountered. Did fire doors close and latch properly? Did staff follow proper procedures? Was the fire panel returned to normal? Did the monitoring company receive fire alarm signal? Who sounded all clear? Comments: On 12/20/22 at 10:30 a.m., the fire drill records were reviewed. The Fire drill report, dated 10/26/22 at 9:00 a.m.,	R 0092	*What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?* No residents were impacted by the absence of two fire drills and the lack of detail on the Fire Drill forms. Maintenance personnel was educated on the monthly fire drill requirement, accurately completing all data on the Fire Drill forms, and sounding the fire alarm during drills. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* All residents had the potential to be impacted, however, no residents were impacted by the absence of two fire drills and the lack of detail on the Fire Drill forms. Maintenance personnel was educated on the monthly fire drill requirement, accurately completing all data on the Fire Drill forms, and sounding the fire alarm during drills. Fire drill was conducted on 1/12/23 with all employees participating. Employees were educated on the fire panel alert system, fire drill policy, acronym RACE, and acronym PASS per policy. Each employee signed off on fire drill	01/12/2023

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	indicated "Comments: Table top discussion due to construction." No other required information was documented on the fire drill form. The Fire drill report, dated 11/30/22 at 4:00 p.m., indicted "Comments: Table top discussion due to construction. All other requested information on the form was left blank. The facility lacked documentation for a fire drill in September 2022 and October 2022. During an interview on 12/21/22 at 8:45 a.m., the Executive Director, indicated a fire drill with an activated alarm should have been conducted monthly starting in September 2022. During a phone interview on 12/20/22 at 1:30 p.m., the Maintenance Director indicated, he did not activate the fire alarm during the fire drills. "The alarm was often activated due to the building construction at that time. The staff would ignore it [the fire drill]." During an interview on 12/21/22 at 10:10 a.m., the receptionist indicated she had not heard the fire alarm sound for the previous 8 weeks. During an interview on 12/21/22 at 9:30 a.m., the Director of Life Enrichment, indicated she "had never heard the fire alarm go off in this building." On 12/21/22 at 8:45 a.m., the Executive Director provided a policy titled Emergency Preparedness, dated 3/1/21, and indicated it was the current policy being used by the facility. A review of the policy, indicated the community regularly tests and evaluates the efficiency, knowledge and response of community staff in implementing, the community's fire emergency plan. A fire drill		sheet for understanding of proper fire drill procedures. *What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur?* The maintenance department will plan the 2023 Fire Drills and obtain approval by the Executive Director. The Executive Director will review and sign off on all Fire Drill documentation to ensure completion. *How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?* The Executive Director will review and sign off each month's Fire Drill reports to ensure proper completion and compliance with regulation. In addition, Fire Drills will be reviewed in quarterly Quality Assurance meetings.	

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	report was used to evaluate staff efficiency during the drill and to document education of the following, use of alarms, transmission of alarms to the fire department, emergency phone call to fire department, response to alarms, isolation of fire, evacuation of immediate area, evacuation of smoke compartment, preparation of floors and buildings for evaluation, and extinguishment of fire.			
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to			

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	have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview and record review, the facility failed to ensure new employees received the second step of a two-step tuberculin skin test for 3 of 5 employees reviewed. (Qualified Medication Aide 7, Server 8, and EVS 9) Findings include: 1. On 12/21/22 at 9:00 a.m., the employee record was reviewed for Qualified Medication Aide (QMA) 7. The record indicated a hire date of 9/26/22. The first step of a two-step tuberculin skin test (a test required for healthcare workers to assess for the presence of tuberculosis; a contagious and potentially serious bacterial disease that mainly affects the lungs) was administered on 9/23/22 at 12:45 p.m. and was read on 9/26/22 at 9:13 a.m. The result was negative. The record for QMA 7 lacked documentation of a second step of a two-step tuberculin test. 2. On 12/21/22 at 9:10 a.m., the employee record was reviewed for Server 8. The record indicated a hire date of 8/25/22. The first step of a two-step tuberculin skin test was administered on 8/22/22 at 11:00 a.m. and was read on 8/24/22 at 4:05 p.m. The result was negative. The employee record for Server 8 lacked documentation of a second step of	R 0121	*What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?* No residents have been impacted by the lack of the second step tuberculin skin test for the new hires identified during survey. The new Human Resources Director has been educated on the requirement for two-step tuberculin testing for all new hires. *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?* No residents have been impacted, however, all residents had the potential to be impacted. The new Human Resource Director has been educated on the requirement for two-step tuberculin testing for all new hires. Staff members identified as missing their second step tuberculin test will be notified and have their tuberculin skin test administered during a facility clinic	01/26/2023

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	a two-step tuberculin test. 3. On 12/21/22 at 9:20 a.m., the employee record was reviewed for Environmental Services Tech (EVS) 9. The record indicated a hire date of 8/25/22. The first step of a two-step tuberculin skin test was administered on 8/14/22 at 1:30 p.m. and was read on 8/16/22 at 5:35 p.m. The result was negative. The employee record for EVS 9 lacked documentation of a second step of a two-step tuberculin test. During an interview on 12/21/22 at 12:42 p.m., the Executive Director (ED) indicated that the employees should have had a second step of the tuberculin skin test after the first step. The ED further indicated that the facility did not have a policy for tuberculin skin tests.		supervised by the Resident Services Director on January 16th and 17th. All initial administrations will be documented within the employee health record with appropriate readings and second step administration date. Employees will be reminded by the Human Resource Director of the 2nd step administration time frame with a second clinic taking place on January 23rd and 24th. *What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur?* The Human Resource Director will keep a log of all employees with dates of tuberculin testing. During initial employment onboarding human resources will track each employee to ensure compliance of reading, second step administration, and second step reading. *How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?* Human Resource Director has completed initial review of all current employees, identifying those who were in violation and correcting. As new employees are hired, human resources will document initial PPD and subsequent testing auditing	

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			monthly for compliance. This log will be presented to the Executive Director for review and approval. Monthly audits will be presented during quarterly Quality Assurance meetings.	
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation and interview, the facility also failed to ensure the 2nd floor laundry room was in good repair. This had the potential to affect 4 of 4 self-mobile cognitively intact residents residing on the 2nd floor of the facility who had access to the laundry room. Finding includes: On 12/21/22 from 11:15 a.m. to 11:45 a.m., during a facility tour with the Administrator, Interim Plant Operations Manager, and the Facility Project	R 0148	*What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?* All residents had the potential to be impacted, however, no residents were impacted by the lack of construction completion in the 2nd floor laundry room. Construction personnel was educated on the importance of completion of the installation of the dryers and the appropriate	01/10/2023

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	Manager, the 2nd floor laundry room, located next to the Crown Point Dining Room, was observed. Upon entry into laundry room, on the left side, there were two unplugged clothes dryers sitting side by side with approximately 18 inches between the machines. The following was observed: - On the floor between the two machines was an uncovered 5-gallon bucket with approximately one half inch of water in the bucket. - Connected behind each machine, was a small hose. The other end of the hose was resting inside the open 5-gallon bucket. - On the wall between the machines, was an un-finished opening in the dry-wall. The opening was approximately 8 inches wide and 14 inches long. - Exposed insulation was observed at the top of the opening and just below the insulation was a 2-inch uncovered drainpipe. During an interview at that time, the Facility Project Manager indicated the dryers were vent-less machines and so a drainpipe had to be exposed to collect the water. At that time, the Facility Project Manager pulled the tubes out of the bucket and inserted them into the drainpipe. The Facility Project Manager indicated their responsibilities for any further repairs for this issue were completed.		means of drainage for the safety and security of our residents. Contractors were able to secure any loose piping and install a protective screen to ensure it was free from debris. *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?* No residents were impacted by the incomplete installation and means of drainage. Current census within this area is 4. Currently all residents have laundry items done by the community and do not utilize this laundry area. *What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur?* To ensure the safety of the current and future residents, environmental rounds will be made daily to assess resident areas and identify potential hazards, construction concerns, or new developments that need attention from maintenance or outside contractors. Each concern will be brought to the Executive Director to determine area of responsibility. Construction issues will be documented within the ProCore system for construction repair requests. Maintenance issues will be logged	

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			within the in-house maintenance request system, Life Loop. Any repairs or maintenance issues not able to be addressed within these two systems will be taken care of by the appropriate vendor contracted to complete the project. Each concern will be discussed within daily team meetings to discuss any potential hazard to residents, any steps that need to be taken to protect the resident, the time frame of work completion and if any other residents are experiencing the same issue. Any construction issues logged within ProCore will be reviewed bi-weekly to determine closure or additional work needed for repair. Life Loop will be reviewed daily to ensure all work orders are addressed within a 24 hour time period and taken to conclusion or the system will be documented with reasoning of any delays.	
R 0155 Bldg. 00	410 IAC 16.2-5-1.5(l) Sanitation and Safety Standards - Deficiency (l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items. Based on observation, interview, and record review, the facility failed to ensure the dumpster area was free of rubbish and dumpster lids were closed for 2 of 2 dumpster area observations.	R 0155	*What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?* No residents were impacted by	01/10/2023

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	Findings include: 1. On 12/20/22 from 11:15 a.m. to 11:20 a.m., during the initial facility tour with the Dietary Manager (DM), the dumpster area, located approximately 30 yards from the kitchen's rear exit door, the following was observed: a. The dumpster area contained two dumpster containers. Each container had two separate attached top lids. The following was observed: -The two lids, for the container to the left side, were observed to not be closed. Inside the container were multiple collapsed boxes and other debris. -One of two lids, for the container to the right side, was observed to not be closed. Inside the container were multiple filled trash bags and other debris. b. On the ground, behind the container to the right side, a broken cabinet was observed. c. On the ground and around both containers, the following was observed: -multiple empty soda pop cans -multiple smashed lemon halves -one partial muffin -multiple unidentifiable food products -multiple collapsed cardboard boxes -multiple long wooden boards and other construction materials. No other staff were visible in the area during that time. During an interview at that time, the DM indicated the dumpster container lids were to be kept closed when not in use; the area was to be kept clean;		the rubbish within the dumpster area or the open dumpster lids. All staff was educated on the importance of keeping this area free of debris to help detour rodents and keeping this area secure for the safety of our resident population. Environmental rounds will occur daily to observe the dumpster area and ensure ground area is free of debris and each dumpster is secured for effective garbage and waste disposal. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* All residents had the potential to be impacted, however no residents were impacted by the rubbish within the dumpster area or the open dumpster lids. Dining Services staff was educated on the importance of keeping this area free of debris and rubbish along with securing all lids upon emptying trash from the dining area. Inservice training was provided to all Astral at Franklin staff regarding the proper procedure for emptying trash or recycled goods into the appropriate containers and ensuring each is secured with no debris. Maintenance personnel or their designee will conduct daily environmental rounds to ensure	

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	and free of debris. All residents residing in the facility received food from the kitchen. 2. On 12/21/22 from 9:25 a.m. to 9:30 a.m., during a follow up observation of the dumpster area, the following was observed: a. The dumpster area contained two dumpster containers. Each container had two separate attached top lids. The following was observed: -The two lids, for the container to the left side, were observed to not be closed. Inside the container were multiple collapsed boxes and other debris. -The two lids, for the container to the right side, was observed to not be closed. Inside the container were multiple filled trash bags and other debris. b. On the ground, behind the container to the right side, a broken cabinet was observed. c. On the ground and around both containers, the following was observed: -multiple empty soda pop cans -multiple lemon halves -multiple unidentifiable food products -used plastic gloves -multiple collapsed cardboard boxes -multiple long wooden boards and other construction materials. No other staff were visible in the area during that time. During an interview at that time, the DM indicated the dumpster area was supposed to be kept clean and the lids were to be kept closed. During an interview on 12/21/22 at 12:45 p.m., the		the dumpster area is free of debris, food, or other items that could be hazardous. Each dumpster will also be observed for proper closure. *What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur?* Daily environmental rounds will be conducted to observe this area. Any violations will be brought directly to the Executive Director for resolution and dealt with accordingly. All new hires will be oriented on proper trash disposal and the importance of keeping this are clean and secure. This will be reviewed during orientation and yearly thereafter. Any violations within this time will be addressed immediately with inservice training and review. *How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?* Daily environmental rounds will consist of audit sheets stating the date, time, what was observed and the corrective action taken. Audit sheets will be reviewed by the Executive Director weekly and signed off to acknowledge completion.	

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	Administrator indicated the facility lacked a dumpster container policy. The dumpster area was to be kept clean and the lids were to be kept closed when not in use. The facility was to follow the state regulations regarding the dumpster area. On 12/21/22 at 3:17 p.m., a review of the Retail Food Establishment Sanitation Requirements - Title 410 IAC 7-24, effective November 13, 2004, indicated, "...receptacles and waste handling units for refuse, recyclables and returnables shall be kept covered with tight-fitting lids or doors if kept outside...accumulation of debris...are minimized...effective cleaning is facilitated around...the unit..."			
R 0187 Bldg. 00	410 IAC 16.2-5-1.6(k) Physical Plant Standards - Deficiency (k) Hot water temperature for all bathing and hand washing facilities shall be controlled by an automatic control valve. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit. Based on observation, interview, and record review, the facility failed to ensure water temperatures were maintained between 100 degrees F (Fahrenheit) and 120 degrees F for 1 of 4 resident rooms and 1 of 1 laundry rooms observed. (Room 220, Laundry Room) Findings include: On 12/21/22 from 11:15 a.m. to 11:45 a.m., during a facility tour with the Administrator, Interim Plant Operations Manager, and the Facility Project Manager, the following was observed:	R 0187	*What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?* One resident was impacted by unstable water temperatures, however all residents had the potential to be impacted. Resident room #220 was impacted by low water temperatures of 87.5 in the kitchen sink area. Plant Operation employees and construction personnel were instructed on the range of approved water temperatures.	12/21/2022

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		A. BUILDING 00 B. WING	12/21/2022

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	1. Room 220's kitchenette sink was observed, and the hot water temperature was tested by the Interim Plant Operations Manager. The hot water temperature was recorded at 87.5 degrees F. During an interview at that time, Resident 680 indicated, since her admission into the facility, the kitchenette hot water "has never gotten very warm." 2. The laundry room was observed. The sink was located on the opposite side of the room from the dryers. The hot water temperature was tested by the Interim Plant Operations Manager. The hot water temperature was recorded at 129 degrees F. During an interview at that time, the Administrator indicated all four residents residing on the 2nd floor were self mobile and cognitively intact had access to the laundry room. The hot water tested above the allowable hot water maximum temperature. On 12/21/22 at 11:50 a.m., the Administrator provided a copy of the water temperature logs. A review of the document indicated the Plant Operations Manager recorded the following: - On 10/13/22, the laundry room recorded water temperature was 130 degrees F. - On 10/27/22, the laundry room recorded water temperature was 128 degrees F. - On 11/10/22, the laundry room recorded water temperature was 128 degrees F. - On 11/13/22, the laundry room recorded water temperature was 140 degrees F. The document lacked water temperature logs for Room 220. During an interview at that time, the Administrator		This deficiency was corrected immediately with installation of the appropriate check valve to regulate water temperature within the resident apartment and this concluded in immediate results. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* All residents had the potential to be impacted, however one resident room was identified to have water temperatures that were out of range. Routine water checks have been initiated two times weekly, testing different resident apartments or common areas to ensure water temperatures are within the approved range. This will be the responsibility of the new Maintenance Technician to ensure consistency with the process of testing. Water temperatures will be logged with dates, room or area location and the water temperature. Any variations from the range will be brought to the attention of the Maintenance Director and Executive Director for immediate investigation and repair. *What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur?* The maintenance department will	

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	indicated 110 degrees F was the maximum allowable hot water temperature for resident use. The hot water temperatures in the resident rooms and in the laundry room was not to exceed 110 degrees F. The temperatures were to be monitored and recorded daily. On 12/21/22 at 12:45 p.m., the Administrator provided a copy of the Franciscan Ministries ("FM") System Policy Plant Operations Hot Water Standards policy, dated 10/1/2000, and indicated it was the current policy in use by the facility. A review of the document indicated, "...regulates the temperatures of hot water utilized for bathing, hand washing, dietary and laundry facilities to meet all applicable Federal and State standards...to ensure the safety of residents exposed to hot water while maintaining temperatures that meet effective sanitation requirement...daily checks and logging of hot water temperatures...Resident areas - maximum temperature 110*F...regular maintenance of automatic mixing valves and devices..."		develop a routine for water checks throughout the building encompassing all resident living units and floors, along with all common area. The Executive Director will review and sign off on all water check logs weekly. *How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?* The Executive Director will review and sign off each weeks logged water checks to ensure proper completion and compliance with regulation. In addition, water temperatures will be reviewed in quarterly Quality Assurance meetings.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure food was served in a sanitary manner for 1 of 2 kitchen observations. Foods were not covered, labeled, or dated; scoops were stored in bulk food containers; and staff members' hair was not covered while in the kitchen food preparation area.	R 0273	*What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?* No residents were impacted by the absence of standards to ensure food was served in a sanitary manner. Dining Services personnel was educated on the	01/12/2023

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	Findings include: On 12/20/22 from 10:45 a.m. to 11:10 a.m., during the initial kitchen tour with the DM (Dietary Manager), the following was observed: 1. The DM was observed walking through-out the food preparation area where the afternoon's special event foods were being prepared and where the noon meal was being prepared. The DM was wearing a small hat. The DM's hair was pulled into a ponytail, approximately 12 inches in length from the base of the neck, was observed to not be covered. The DM had multiple loose hairs, located in front of the ears and approximately 5 inches in length, were observed to not be covered. 2. The Dietary Cook 2 was observed walking through-out the food preparation area where the afternoon's special event foods were being prepared and where the noon meal was being prepared. Dietary Cook 2 was observed wearing a small hat. Dietary Cook 2's hair, approximately 6 inches in length, located below the cap and in front of the ears was observed to not be covered. 3. The small deli refrigerator, located next to the steam-table area, was observed. Inside the refrigerator, a tub of butter and a plate of sliced cheese was observed to not be covered, labeled, or dated. 4. The small refrigerator, located below the grill area, was observed. Inside the refrigerator, an opened plastic bag of sliced ham and an uncovered medium bowl of tuna salad was observed to not be covered, labeled, or dated.		food storage and handling requirement, appropriate labeling and dating of food, and appropriate hair coverage policy. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* All residents had the potential to be impacted, however, no residents were impacted by the deficient practice. All dining services staff were provided inservice training regarding the regulation, policy and practice of proper food storage, labeling, dating of food and all infection control measures. A change in leadership for this department was made to help ensure all regulatory requirements are met to ensure safety for our resident population. *What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur?* Comprehensive audit sheets tracking proper storage, handling, labeling of food items will be conducted weekly for one month by Dining Services Director or designee. If all areas of concern are addressed and corrected, audits will then be conducted monthly. Executive Director will review weekly and monthly audits to determine compliance and sign to acknowledge. Executive	

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	5. On a shelf inside the walk-in freezer, an ice cream scoop was observed resting on an ice cream lid. On the shelf and next to the lid and ice cream scoop, a large partially full ice cream tub was observed to be not covered or dated. 6. In the dry food storage area, located near the food preparation area, the following was observed: - An unlabeled large plastic bulk container was approximately 1/3 full of a white powdery substance and contained a plastic scoop inside the container. The scoop was partially covered by the food item. The container lacked a label or date to indicate what the food item was and when it was placed into the container. - An unlabeled large plastic bulk container was approximately ½ full of a white substance and contained a plastic scoop inside the container. The scoop was partially covered by the food item. The container lacked a label or date to indicate what the food item was and when it was placed into the container. - An unlabeled large plastic bulk container was approximately ½ full of a brown food substance and contained a plastic scoop inside the container. The scoop was partially covered by the food item. The container lacked a label or date to indicate what the food item was and when it was placed into the container. During an interview at that time, the DM indicated staff hair was to be covered; foods were to be labeled, covered, and dated; food containers were to be kept closed; and no scoops were to be left in the bulk food containers. On 12/21/22 at 12:10 p.m., the Administrator provided a copy of the Safety and Sanitation Hair Restraints / Beard Guards policy, dated 11/18/13,		Director will conduct monthly sanitation check of dining services area to ensure compliance. *How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?* Weekly and then monthly audits will be reviewed by Dining Services Director or designee for compliance. Any areas of concern will be addressed and corrected immediately. Weekly and then monthly audits will be provided to Executive Director for review and approval. These audits along with monthly sanitation check of dining services area will be reviewed in quarterly Quality Assurance Meetings.	

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	and indicated it was the current policy in use by the facility. A review of the document indicated, "...hair nets must be worn by all who are in the kitchen production area...refer to local state requirements..." On 12/21/22 at 12:10 p.m., the Administrator provided a copy of the Franciscan Advisory Services Dining Services Procedure Food Storage policy, dated 10/25/22, and indicated it was the current policy in use by the facility. A review of the document indicated, "...all products should be dated upon receipt...if a product is removed from its original packaging, it should be tightly completely wrapped, placed into a sealable plastic bag or container with tight-fitting lid then label and dated...all dry storage bins should be labeled dates and free of any scoops..." On 12/21/22 at 2:55 p.m., a review of the retail Food Establishment Sanitation Requirements Title 10 IAC 7-24, effective November 13, 2004, indicated: "...refrigerated, ready to eat, potentially hazardous food prepared...shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises...discarded...covered containers, or wrappings...wrap food tightly to prevent cross contamination...working containers holding food or food ingredients that are removed from their original packages for use in the retail food establishment, such as...flour...sugars...shall be identified with the common name of the food...handles above the top of the food within containers or equipment that can be closed, such as...sugar...food employees shall wear hair restraints...hair coverings or nets...that are designed and worn to wear effectively keep their hair from contacting...exposed food..."			