

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155617	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER Waters of Chesterfield Skilled Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 524 Anderson Rd Chesterfield, IN 46017	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09676</p> <p>Based on observation, interview, and record review, the facility failed to develop and provide a menu to encourage intake and promote dignity for residents who received a pureed diet for 3 of 3 residents who received pureed diets. (Residents 1, 16, and 7)</p> <p>Findings include:</p> <p>A current Facility menu, item and portion size guide (spread sheets) for lunch on Thursday 1/9/25 indicated the following meals were menued to be served:</p> <p>Regular Diet:</p> <p>BBQ chicken wings, herb roasted potatoes, broccoli florets, chilled peaches, and a dinner roll.</p> <p>The Pureed Diet was menued to receive all of the above items in pureed form.</p> <p>During a lunch meal observation on 1/9/25 from 12:00 p.m. to 12:36 p.m., the following food items were served:</p> <p>Regular diet trays were served breaded chicken nuggets/boneless chicken wings with a side of BBQ sauce, steamed broccoli florets, roasted herbed potatoes, and pudding as a substitute for peaches.</p> <p>During an interview on 1/9/25 at 12:25 p.m., the Acting Dietary Manager (ADM) indicated pudding was a substitute for peaches due to availability.</p> <p>Residents 1, 16, and 7 were served pureed grilled chicken, mashed potatoes, and a pureed vegetable blend.</p> <p>During an interview on 1/9/25 at 12:30 p.m., the ADM indicated he hadn't followed the recipes and menus because he didn't have the time.</p> <p>Review of portion size guide and food type menus (spread sheets) for the week of 1/5/25 to 1/12/25 identified the following concerns regarding lack of variety and/or the failure to serve residents with pureed diets the same meal as other residents, when possible, as follows:</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. 4 of 7 days had a menu for pureed diets to receive pureed buttered carrots: 1/5/25 lunch, 1/9/25 dinner, 1/10/25 lunch, and 1/11/25 dinner.</p> <p>On 1/5/25 the pureed buttered carrots were served as salad when the regular diet was Caesar salad.</p> <p>On 1/9/25 the pureed buttered carrots were served as a vegetable when the regular diet was mixed vegetables.</p> <p>On 1/10/25 the pureed buttered carrots were served as a vegetable when the regular diet was peas and carrots.</p> <p>On 1/11/25 the pureed buttered carrots were served when the regular diet was mixed vegetables.</p> <p>b. Pureed pork was menued to be served for both lunch and dinner on 1/10/25.</p> <p>On 1/10/25 lunch all diet types were menued to receive roast pork.</p> <p>On 1/10/25 dinner, regular diets were to receive Kielbasa when pureed diets were menued for pureed pork, resulting in the same meat being served twice in day.</p> <p>c. Apple sauce with cinnamon was menued to be served for pureed diets for both lunch and dinner on 1/8/25.</p> <p>On 1/8/25 at lunch, the regular diet was apple crisp and the pureed diet was apple sauce. On 1/8/8/25 at dinner, all diet types were menued to receive apple sauce.</p> <p>d. Pureed ranch pasta salad was menued to be served for pureed diets two days in a row 1/6/25 and 1/7/25.</p> <p>e. Vegetable juice was menued to be served 3 of 7 days of the week: 1/5/25 dinner, 1/8/25 dinner, and 1/12/25 dinner</p> <p>On 1/5/25 at dinner, vegetable juice was served as a salad to pureed diets when regular diets were served [NAME] slaw.</p> <p>On 1/8/25 at dinner, regular diets were served house garden salad and pureed diets were menued to be served vegetable juice.</p> <p>On 1/12/25 at dinner, pureed diets were menued to receive vegetable juice when regular diets were served tossed salad.</p> <p>f. Mashed potatoes were menued to be served 4 meals during the week: 1/6/25 lunch, 1/9/25 dinner, 1/11/25 breakfast and dinner.</p> <p>On 1/6/25 at lunch all diet types were menued to receive mashed potatoes.</p> <p>On 1/9/25 at dinner, pureed diets were menued to receive mashed potatoes when regular diets were served potato chips.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/11/25 at breakfast, pureed diets were menued to receive mashed potatoes when regular diets were menued to receive hash brown potatoes.</p> <p>On 1/11/25 at dinner, all diets were menued to receive mashed potatoes. This resulted in those residents who received pureed diets being menued to receive mashed potatoes two times in one day.</p> <p>Resident 1's clinical record was reviewed on 1/10/25 at 10:14 a.m. Current diagnoses included TIAs (Transient Ischemic Attack), dysphasia, major depressive disorder, and delusional disorder. The resident had a current physician's order for a pureed diet. The diet order originated 12/29/2024.</p> <p>An 11/12/24, annual, MDS indicated the resident was severely cognitively impaired.</p> <p>The resident had a current, 11/13/24, care plan problem/need regarding being at nutritional risk.</p> <p>Resident 16's clinical record was reviewed on 1/10/25 at 10:16 a.m. Current diagnoses included diabetes mellitus, hypertension, and dysphasia. The resident had a current physician's order for a pureed diet. This order originated 11/25/2024.</p> <p>An 11/15/24, quarterly, MDS indicated the resident was severely cognitively impaired.</p> <p>The resident had a 11/6/2024, care plan problem/need regarding nutritional risk.</p> <p>Resident 7's clinical record was reviewed on 1/10/25 at 10:19 a.m. Current diagnoses included congestive heart failure, chronic kidney disease, and gastro-esophageal reflux disease. The resident had a current physician's order for a pureed diet. The order originated 9/19/2023.</p> <p>A 12/26/24, quarterly, MDS indicated the resident was severely cognitively impaired.</p> <p>The resident had a current, 10/6/2024, care plan problem/need regarding nutritional risk.</p> <p>A current, 1/7/25, facility policy titled, Resident Rights, provided by the Administrator following the entrance conference on 1/7/25, indicated: .The resident has the right to a dignified existence, self-determination . A facility must protect and promote the right of each resident</p> <p>A current, 4/5/24, facility policy titled Menus, provided by the Administrator on 1/9/25 ay 3:15 p.m., indicated . Menus shall provide a variety of foods and indicate standard portions at each meal. Menus shall be varied for the same day of consecutive weeks</p> <p>3.1-3(a)</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>48146</p> <p>Based on record review and interview, the facility failed to provide the appropriate 48-hour notification of Medicare A Non-coverage for 2 of 2 residents reviewed for Beneficiary Notifications. (Residents 37 & 38)</p> <p>Findings include:</p> <p>On 1/8/25 at 1:23 p.m., the SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review Forms were reviewed for Residents 37 and 38, and indicated the following:</p> <p>1. Resident 37 was admitted to Medicare Part A Skilled Services on 7/24/24. The last covered day of Part A services was 9/10/24. The Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) and SNF Notice of Medicare Non-Coverage (NONMC) were reviewed with the resident's representative and signed on 9/10/24.</p> <p>A 9/9/24, Detailed Explanation of Non-coverage form indicated Resident 37 had reached the maximized functional potential for physical and speech therapy.</p> <p>2. Resident 38 was admitted to Medicare Part A Skilled Services on 8/13/24. The last covered day of Part A services was 9/11/24. The SNF ABN and SNF NONMC were reviewed with the resident's representative and signed on 9/10/24.</p> <p>A 9/10/24, Detailed Explanation of Non-coverage form indicated Resident 38 had reached the maximized functional potential for physical, occupational, and speech therapy.</p> <p>During an interview, on 1/10/25 at 9:34 a.m., LPN 3 indicated she was the Social Service Director at the time. The process for when a resident was discharged from any therapy service was for the therapy department to notify the Social Service department of the last day of covered services. She indicated there were times when she was not given the full two days advanced notice before services ended. The resident representatives needed to review and sign the NOMNC and ABN forms and this was sometimes difficult to complete. She aimed to complete this on the same day as she was notified by therapy.</p> <p>During an interview, on 1/13/24 at 10:35 a.m., Speech Therapist (SLP) 4 indicated the therapy discharge forms were filled out a week in advance and provided to the Social Services (SS) and Minimum Data Set (MDS) departments. SLP 4 indicated the facility had a weekly Medicare A meeting where the residents on caseload were discussed and any upcoming discharges were reviewed. The SS and MDS departments attended these meetings.</p> <p>(continued on next page)</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An undated, current facility policy, titled, Advanced Beneficiary Notices, provided by the Administrator on 1/13/25 at 10:51 a.m., indicated the following: .It is the policy of the facility to follow the Medicare requirements for issuing Advanced Beneficiary Notices and Notices of Non-coverage of services as defined in the Medicare Claim Processing manual, Chapter 30 . The SFN ABN must be issued Prior to receiving the non-covered care . The Notice/Form will be completed per the CMS guidelines by a facility designee .The Center of Medicare and Medicaid Services (CMS) require a Notice of Medicare Non-coverage (NOMNC) Notice to be issues to Medicare Beneficiaries who are receiving Services from the skilled nursing facility to inform them that their Medicare covered services are ending .The NOMNC will be issues to the Traditional Medicare A Beneficiaries or the authorized representative, 2 days prior to the Medicare coverage ending when the Beneficiary has days remaining</p> <p>3.1-4(f)(3)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>48146</p> <p>Based on record review and interview, the facility failed to notify the physician as ordered for changes in daily weights for 1 of 1 resident reviewed for weight loss/gain. (Resident 5)</p> <p>Finding includes:</p> <p>Resident 5's record was reviewed on 1/9/25 at 2:24 p.m. Diagnoses included heart failure, hypertension, and unspecified edema.</p> <p>Physician's orders included, but were not limited to,</p> <p>a. Monitor 1600 millimeter (mL) fluid restriction daily, 360 mL per meal. The order was dated 11/21/24.</p> <p>b. Take daily weight and notify the physician for an increase of 3 pounds (lbs) in 24 hours or an increase of 5 lbs in 7 days. The order was dated 11/22/24.</p> <p>c. Give one torsemide (a diuretic) 40 milligrams (mg) tablet twice daily for edema. The order was dated 11/29/24.</p> <p>Review of the resident's documented weights, included, but were not limited to, the following:</p> <p>a. On 12/24/24, the resident's weight was 362.6 pounds. On 12/23/24, the resident's weight was 353.0 pounds. This was an increase of 9.6 pounds in 24 hours. The record lacked a physician notification regarding weight gain.</p> <p>b. On 12/27/24, the resident's weight was 362.0 pounds. On 12/26/24, the resident's weight was 347.2 pounds. This was an increase of 14.8 pounds. The record lacked a physician notification regarding weight gain.</p> <p>c. On 12/31/24, the resident's weight was 360.6 pounds. On 12/30/24, the resident's weight was 354.0 pounds. This was an increase of 6.6 pounds. The record lacked a physician notification regarding weight gain.</p> <p>A care plan, dated 9/20/24, related to congestive heart failure risks and complications included, but was not limited to, the following interventions: Fluid restriction as ordered, medications as ordered, and monitor for signs and symptoms of an exacerbation.</p> <p>During an interview, on 1/13/24 at 11:17 a.m., LPN 5 indicated the weights and physician notifications were documented in the electronic medical record.</p> <p>During an interview, on 1/13/24 at 11:54 a.m., the DON indicated the weights were documented in the vitals section of the electronic medical record. This resident was being seen weekly by the Nurse Practitioner (NP) since she was aware of his weight fluctuations. She indicated she was not able to locate documentation indicating the physician or NP were notified of weight gain as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A current facility policy, dated 6/18/23, titled, Guidelines for physician orders-(following physician orders), provided by the Administrator on 1/13/25 at 1:32 p.m., indicated the following: .4. All physician orders received pertaining to the resident will be implemented and followed throughout the course of the resident's stay in the facility as the orders are received</p> <p>3.1-37(a)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48146</p> <p>Based on observation and interview, the facility failed to ensure insulin (a medication to treat diabetes mellitus) vials were dated when opened and disposed of when expired for 1 of 2 carts reviewed for medication storage. (200 hall cart)</p> <p>Finding includes:</p> <p>During a medication storage observation of the 200 hall cart, accompanied by RN 6 on [DATE] at 10:22 a.m., the following was observed:</p> <p>One open vial of Lantus (long-acting) insulin, dated [DATE]; the vial contained approximately 40 units.</p> <p>One open vial of Lantus (long-acting) insulin, undated; the vial contained approximately 260 units.</p> <p>One open vial of Novolog (rapid-acting) insulin, undated; the vial contained approximately 200 units.</p> <p>During an interview at the time of the observation, RN 6 indicated insulin was good for 28 days and the insulin dated [DATE] was expired and should no longer be used. The undated insulin pens had one or more doses used and should have been dated when opened.</p> <p>During an interview, on [DATE] at 11:37 a.m., the DON indicated insulin pens should be dated when opened and discarded when expired. The expiration date for insulin is 28 days after it's been opened.</p> <p>A current facility policy, dated [DATE], provided by the DON on [DATE] at 11:37 a.m., indicated the following: .3. Upon opening for the first time, the insulin pen will have a date sticker applied. This will be done by the nurse. The date will reflect the date the seal was broken for use .6. Insulin pens will be considered expired after 28 days and up to 45 days depending on the manufacturer's instructions---after they are opened, no matter the amount of insulin remaining in the pen</p> <p>3XXX,d+[DATE](j)</p> <p>3XXX,d+[DATE](k)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>09676</p> <p>Based on observation, interview and record review, the facility failed to ensure food was prepared and served under safe and sanitary conditions. This deficient practice had the potential to impact 39 of 39 facility residents.</p> <p>Finding include:</p> <p>During a lunch meal service observation on 1/9/25 from 12:00 p.m. to 12:40 p.m. the following concerns regarding food handling, food distribution, hand washing, glove use, and prevention of cross contamination were made:</p> <p>The Acting Dietary Manager (ADM) was wearing gloves on both hands. He began meal services, touching meal tickets, meal trays, bowls, counter tops, lids, utensils, napkin wrapped silverware, and the food contact surface of plates with his gloved hands. He picked up cooked chicken nuggets/boneless chicken wings with his contaminated gloves and placed the chicken on meal plates. At 12:04 p.m., he left the kitchen through the rear door by the refrigerators and freezers. He touched the door handle with his gloved hands. He returned carrying dinner rolls in bags.</p> <p>With his soiled gloved hands, he touched the bag of the dinner rolls. He tore the bread bag open. He placed 5 dinner rolls on trays. With the same soiled gloves he returned to the process of touching meal tickets, meal trays, napkin wrapped silverware, bowls, counter tops, lids, utensils, and the food contact surface of plates with his gloved hands. He then picked up chicken nuggets/boneless chicken wings and rolls with his contaminated gloves and placed the food items on meal plates.</p> <p>At 12:10 p.m., he left the serving area. Wearing the same contaminated gloves, he touched counter tops, cabinet fronts, cabinet handles, the refrigerator, obtained a bag of broccoli, and obtained a steam table pan. With the same contaminated gloved hands, he opened the broccoli and placed the broccoli in the steam table pan. He touched the broccoli with his soiled gloved hands and rearranged the broccoli in the pan. He knocked a small black triangular object from the table and retrieved it from the floor using his contaminated gloved hands. He then used his soiled gloves to open the steamer and place the broccoli inside.</p> <p>After placing the broccoli in the steamer, he returned to the steam table again touching items with his contaminated gloved hands. He returned to touching, meal tickets, meal trays, napkin wrapped silverware, bowls, counter tops, lids, utensils, and the food contact surface of plates with his gloved hands. He picked up chicken nuggets/boneless chicken wings and rolls with his contaminated gloves and placed the food items on meal plates. He began to occasionally pick up roasted potatoes with his soiled gloves and place them on the meal tray as well.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>At 12:15 p.m., he left the serving area once again, he checked potatoes in the oven. He touched the potatoes with his contaminated gloved hands as if checking for tenderness. He then returned to the steam table area. With his soiled gloved hands, he returned to touching meal tickets, meal trays, napkin wrapped silverware, bowls, counter tops, lids, utensils, and the food contact surface of plates. He picked up chicken nuggets/boneless chicken wings and rolls with his contaminated gloves and placed the food items on meal plates. Occasionally, he pick up roasted potatoes with his soiled gloves and placed them on the meal tray as well.</p> <p>At 12:17 p.m., he left the food service area, he went to the oven and food prep area in the kitchen. He placed a new pan of broccoli on the steam table. He took a pan to the dish room. He used the spray hose at the three compartment sink to spray down the pan. He stuck his contaminated gloved hands in a sink of sudsy water. He removed his gloves and threw them away. He then pulled gloves from his pocket or apron and placed them on his now bare hands. He did not wash his hands prior to putting on the new pair of gloves. He returned to the steam table and began serving with the newly applied gloves. He returned to using the same process of serving as he had previously. He touched meal trays, meal tickets, bowls, food service contact surfaces of plates, napkin wrapped silverware, chicken nuggets, rolls, and roasted potatoes.</p> <p>At 12:19 p.m., he broke apart large pieces of broccoli using his contaminated gloves and placed the broccoli on meal plates.</p> <p>At 12:20 p.m., he drank from his water bottle while wearing his contaminated gloves. He then wiped his mouth on the back of his gloved hand and returned to the steam table area. With his soiled gloved hands, he returned to touching meal tickets, meal trays, napkin wrapped silverware, bowls, counter tops, lids, utensils, and the food contact surface of plates. He picked up chicken nuggets/boneless chicken wings and rolls with his contaminated gloves and placed the food items on meal plates. He also occasionally pick up roasted potatoes with his soiled gloves and place them on the meal tray as well. Periodically, he broke large broccoli with his contaminated gloved and placed the smaller pieces on meal trays.</p> <p>At 12:25 p.m., he brushed meal tickets off the counter onto the floor. He picked the meal tickets up from the floor using his contaminated gloved hands. Using his soiled gloved hands, he returned to serving meals touching food, dishes and utensils in the same manner he had been using since 12:00 p.m.</p> <p>At 12:27 p.m., with his soiled gloved hands, he took off his ball cap, smoothed the cap, and re-applied it. He returned to meal services using his contaminated gloves to once again touch food, dishes, and utensils.</p> <p>At 12:28 p.m., he took all the food off a standard plate using his contaminated gloves. He placed all the food he had removed on a divided plate and served the meal to a resident.</p> <p>At 12:30 p.m., he left the food service area and went to the stove. With his contaminated gloved hands, he removed roasted potatoes from the oven. He then used his soiled gloved hands and a steam table lid to pour and scrape roasted potatoes off a cooking sheet into a steam table pan.</p> <p>During the lunch meal service from 12:00 p.m. to 12:40 p.m., every chicken nugget and roll served was placed on a meal plate was done using contaminated gloves.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 1/9/25 at 12:36 p.m., the Acting Dietary Manager (ADM) indicated he should have used tongs to serve the chicken and rolls, but if he had done so it would take too long to serve them. He did not believe he had contaminated his gloves at any time during meal service.</p> <p>During an interview on 1/9/25 at 1:45 p.m., the Director of the contracted dietary food services company indicated the ADM should have used utensils to served food. The use of gloves instead of utensil increased the risk for cross contamination.</p> <p>A current, undated policy titled, Food Handling, provided by the Administrator on 1/9/25, at 3:15 p.m., indicated prepared food items will be served with serving utensils so as to avoid hand contamination.</p> <p>A current, undated facility policy titled Glove Use, provided by the Administrator on 1/9/25 at 3:15 p.m., indicated 2. Staff will use clean barriers such as single-use gloves, tongs, deli paper, and spatulas when handling food. 3. Gloved hands are considered a food contact surface that can get contamination or soiled. If used single use gloves shall be used for only one task (such as working with ready to eat food or with raw animal food), used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in operation. 4. Hands are to be washed when entering the kitchen and before putting on the single-use gloves (before beginning work with food) and after removing single use gloves.6. Gloves are just like hands. They get soiled/anytime a contaminated surface is touched, the gloves must be changed, and the hands must be washed.</p> <p>A current, undated facility policy, titled, Handwashing, provided by the Administrator in 1/9/25 at 3:15 p.m., indicated the following:</p> <p>.When to wash hands:</p> <p>a. When entering the kitchen at the start of a shift.</p> <p>b. After touching bare human body parts .</p> <p>.e After .eating or drinking.</p> <p>f. After handling soiled equipment or utensils.</p> <p>g. During food preparation</p> <p>3.1-21(i)(1)</p>		