PRINTED: 02/16/2022
FORM APPROVED

CENTERS FOR	ENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039								
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	ETED		
		155799	B. W	ING		01/20	/2022		
		<u> </u>	_	STREET A	ADDRESS, CITY, STATE, ZIP COD				
NAME OF I	PROVIDER OR SUPPLIEF	₹	614 WEST 14TH STREET						
APERION CARE MARION LLC			MARIO	N, IN 46953					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
F 0000									
Bldg. 00									
	This visit was for th	ne Investigation of Nursing	F 00	000	Preparation and/or execution	of			
	Home Complaint II	N00371088. This visit included			this plan of correction does no	t			
	the Investigation of	Residential Complaint			constitute admission or agree	ment			
	IN00371105.				by the provider of the truth of				
					facts alleged or conclusions s	et			
	•	1088- Substantiated.		forth in the statement of					
		iencies related to the		deficiencies. The plan of					
	allegations are cited	d at F684, F804 and F812.		correction is prepared and/					
	Complaint IN00271	1005- Substantiated. State			executed solely because it is				
	-	o the allegations are cited at	-		required by the provisions of federal and state law. the fact	lity /			
	R0268, R0272 and	_			respectfully request a desk re	-			
	K0200, K02/2 and	K0273.			for these alleged deficient	VIEW			
	Survey dates: Janu	ary 19 and 20, 2022			practices.				
	Facility number: 01	2809							
	Provider number: 1								
	AIM number: 2011	36580							
	Census Bed Type:								
	SNF: 6								
	NF: 26								
	Residential: 6								
	Non-Certified Com	prehensive: 14							
	Total: 52								
	Census Payor Type								
	Medicare: 6	•							
	Medicaid: 26								
	Other: 14								
	Total: 46								
	-								
	These deficiencies accordance with 41	reflect State Findings cited in 0 IAC 16.2-3.1.							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Quality review completed on January 28, 2022.

TITLE

(X6) DATE

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 2J3Z11 Facility ID: 012809 If continuation sheet Page 1 of 24

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155799	B. W	NG		01/20	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	2			ST 14TH STREET		
APERION	N CARE MARION L	LC		MARION, IN 46953			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0684	483.25						
SS=D	Quality of Care	-					
Bldg. 00	§ 483.25 Quality o						
	-	a fundamental principle that					
		ment and care provided to					
	facility residents. I						
	•	ssessment of a resident, the					
	-	re that residents receive e in accordance with					
		lards of practice, the					
	•	erson-centered care plan,					
	and the residents'						
		on, interview and record	F 00	584	F684 Quality of Care		02/03/2022
		failed to follow physician	1 00	70-7	1 00 1 Quality of Gard		02/03/2022
		al supplements for 3 of 6			1) Corrective actions which w	ill be	
		for dietary supplements.			accomplished for those		
	(Resident B, D and				employees and residents foun	nd to	
	,	,			have been affected by the def		
	Findings include:				practice:		
	During an observ	vation on 1/20/22 at 8:30 a.m.,					
		eakfast tray that included			Residents B, D and G orders	were	
		crambled eggs and milk. The			reviewed, and are receiving		
	tray lacked any sup	plements.			nutritional supplements per M	D	
					orders.		
		cket on 1/20/22 at 10:00 a.m.,					
		gular diet and dental soft			2) How will the facility identify	′	
		t. The meal ticket lacked any			other residents having the		
	nutritional supplem	ents			potential to be affected by the		
	The eliminature 1	for Davidant Davis			same deficient practice?		1
		for Resident B was reviewed			Facility wide and trues as a deci	at a d	
		a.m. Diagnoses included, but dementia, dysphagia,			Facility wide audit was conduct of all residents with orders for	Jieu	
	osteoporosis and an				nutritional supplements to ens	ura	
	ostcoporosis and an	Aioty.			they are receiving supplement		
	A health care plan	dated 10/19/18, indicated the			per MD orders.	ıo	
	_	nutrition and hydration			per Mib orders.		
		's disease and dysphagia.			3) The measures the facility v	vill	
		led, but were not limited to,			take or systems the facility wil		
		ered and monitor weights.			alter to ensure that problems		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2J3Z11

Facility ID: 012809

If continuation sheet Page 2 of 24

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	` ′		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	00	COMPL	
		155799	B. WING			01/20/	2022
NAME OF F	PROVIDER OR SUPPLIER	}			ADDRESS, CITY, STATE, ZIP COD		
					ST 14TH STREET		
APERIO	N CARE MARION L	LC	M	IARIO	N, IN 46953		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II	)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TA	AG	DEFICIENCY)		DATE
		1 . 112/12/20 : 1: . 1.			be corrected or will not recur:		
		, dated 12/13/20, indicated to			D: 1		
	1 ~	es in the evening and twice in			Dietary and nursing staff were		
	the morning to main	ntain weight.			in-serviced on facilities "Physic		
	Review of the December 2021 and January 2022				Orders-Entering and Processi	ng	
		ff documented daily			policy.		
	consumption of the	-			Quality Assurance plans to		
	251154111ption of the	-app-omenu			monitor facility performance to		
	2. Review of a meal ticket on 1/20/22 at 10:00 a.m.,				make sure that corrections are		
	Resident D had a regular diet and regular texture				achieved and are permanent:		
	on the ticket. The meal ticket lacked any				aomoroa ama aro pormanomi		
	nutritional supplements.				QA tools were created to mon	itor	
					and ensure that residents with		
	During an observation and interview on 1/20/22 at				orders for nutritional suppleme	ents	
	9:10 a.m., Resident	D indicated the food "sucked."			are receiving them per MD ord	ders.	
	He did not usually a	get was he ordered and the			QA checks will be conducted		
	amounts were pretty	y small. The only snacks he			randomly for five residents per	r	
	received were broug	ght in from his wife. Last			week with orders for suppleme	ents	
	night, he got a hotd	og on a bun and pea salad.			for four weeks then monthly.	The	
		have any nutritional			results of these audits will be		
	supplements on his	meal tray.			reviewed in QA meeting month	-	
					for six months or until an avera	_	
		for Resident D was reviewed			of 90% compliance or greater		
		o.m. Diagnoses included, but			achieved for three consecutive	_	
		dysphagia, protein-calorie			months. The QA Committee v		
	malnutrition, hyper	lipidemia and hemiplegia.			identify any trends or patterns		
	A 1 1/1 1	1 . 112/6/21 . 1 1			make recommendations to rev		
	·	dated 12/6/21, indicated			the plan of correction as indica	ated.	
	encourage intake of	f meals, snacks and fluids.					
	A physician's order	, dated 12/8/21, indicated to					
		oplement (high risk for					
	malnutrition) 2.0 th						
	, ,	,					
	Review of the December 2021 and January 2022						
MAR and TAR, staff documented three times							
	daily consumption						
	_						
	3. Review of a mea	al ticket on 1/20/22 at 10:00 a.m					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155799		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       00       COMPLETED         B. WING       01/20/2022				
	OF PROVIDER OR SUPPLIE		614 W	ADDRESS, CITY, STATE, ZIP COI EST 14TH STREET DN, IN 46953	•	
(X4) II PREFI		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS DEFENDED TO THE ADDRESS OF THE ACTION SHOULD BE ADDRESS OF THE ADDRESS OF THE ACTION SHOULD BE	JLD BE COMPLETIO	)N
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	DATE	
	Resident G had a regular diet and mechanical soft texture on the ticket. The meal ticket lacked any nutritional supplements.					
	on 1/20/22 at 11:00 were not limited to hemiplegia, hemip	The clinical record for Resident G was reviewed on 1/20/22 at 11:06 a.m. Diagnoses included, but were not limited to, anemia, heart failure, hemiplegia, hemiparesis and cognitive communication deficit.				
	A physician's order, dated 4/28/21, indicated to provide a MightShake (dietary calories and protein supplement) 4 times daily.					
		Another order, dated 11/3/21, indicated to provide a Magic Cup three times daily.				
		ember 2021 and January 2022, laily consumption of both				
	Manger 8 on 1/20/2 she has never pulle B, D or G. The for orders in the comp would then be on to	w with Cook 1 and Dietary 22 at 9:58 a.m., Cook 1 indicated any supplement for Resident armer manager would put the diet atterner for any supplements and it their meal ticket. She had no olements other than what was				
	indicated the Magi kitchen and she con supplement this mo	w 1/20/22 at 11:17 a.m., LPN 5 cShake should come from the uld not say if Resident B had orning. She indicated her family in some food items and keeping rator in her room.				
	documented, but d	1 a.m., QMA 6 indicated she id not see the supplement on A CNA told her the resident				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2J3Z11

Facility ID: 012809

If continuation sheet Page 4 of 24

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		155799	B. W	ING		01/20	/2022
	PROVIDER OR SUPPLIER			614 WE	DDRESS, CITY, STATE, ZIP COD ST 14TH STREET N, IN 46953		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDEDIC DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		the drink. She indicated they					
		nt in the refrigerator and/or					
	freezer at the nurses' station.						
	The refrigerator and	l freezer on D-Hall was					
		2 at 11:35 a.m. and no					
	supplements were n						
	11						
		facility policy, dated 8/22/17,					
	titled "Physician Or	_					
		ed by the Administrator on					
	1/20/22 at 11:10 a.m., indicated the following: "Purpose: To provide general guidelines when receiving, entering, and confirming physician or prescriber's						
	orders.	iming physician of presented s					
		g physician's orders by					
	telephone:						
	Enter the order into	the resident's chart under					
	"order" tabinclud	e a diagnosis or indication for					
	use"						
	This Federal tag rel	ates to Complaint IN00371088.					
	3.1-37(a)						
F 0804	483.60(d)(1)(2)						
SS=E		pear, Palatable/Prefer					
Bldg. 00	Temp						
	§483.60(d) Food a						
		eives and the facility					
	provides-						
	8483,60(d)(1) Foo	od prepared by methods that					
	conserve nutritive						
	appearance;	•					
	. , , ,	od and drink that is					
	•	e, and at a safe and					
	appetizing temper	ature.	1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2J3Z11

Facility ID: 012809

If continuation sheet Page 5 of 24

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	ETED
		155799	B. WI	NG		01/20/2	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			EST 14TH STREET		
APERIO	N CARE MARION L	LC			N, IN 46953		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	R'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
		on and interview, the facility	F 08	304	F804 Nutritive Value/Appear,		02/03/2022
		dents' meals were palatable for			Palatable/Prefer Temp		
		iewed for meals (Resident C, D					
	and F ).				1)Corrective actions which wil	l be	
					accomplished for those		
	Findings include:				employees and residents four		
		1/10/00			have been affected by the def	icient	
	_	iew on 1/19/22 at 8:22 a.m.,			practice:		
		d the other day, they received					
		.m. and then turned around and			Facility staff are providing		
	received lunch. Recently, the Administrator				Residents C, D and F with the		
	ordered Papa Johns for lunch and Fazoli's for				menu daily, a day in advance		
	supper. The next day they had Kentucky Fried				the facility's alternative option		
	Chicken. She was not being offered any snacks, but had her own. When and if they get a menu,				well. Staff are communicating	-	
		it they ordered and they have			residents C, D and F's prefere		
		tray a couple of times, but she			back to the dietary departmen	II.	
		now. The food was generally			2) How will the facility identify	,	
	not very good.	now. The food was generally			other residents having the	′	
	not very good.				potential to be affected by the		
	The clinical record	for Resident C was reviewed	same deficient practice?				
		a.m., Diagnoses included, but			Same denoient practice:		
		chronic obstructive pulmonary			All residents have the potentia	al to	
		ellitus, protein-calorie			be affected by the alleged	15	
	malnutrition and ne	• •			deficiency.		
		• •			ĺ		
	A health care plan,	dated 3/8/19 and revised			3) The measures the facility v	will	
	_	he resident had a nutritional			take or systems the facility wil		
		ow-salt diet and diabetes			alter to ensure that problems		
	mellitus. Interventi	ons included, but were not			be corrected or will not recur:		
	limited to, provide	and serve diet as ordered and					
	make diet change re	ecommendations.			Facility reinforced their proces	ss to	
					ensure all residents will receive	∕e a	
		riew on 1/19/22 at 2:15 p.m.,			copy of the menu, as well as a	a list	
		d they have forgotten a tray a			of substitutions which can be		
	_	e will then tell them. He would			requested if they prefer some	thing	
		wn food and his father and son			other than the standard menu		
		st food. He indicated the			items. Facility staff also		
	_	tty small, they do not get what			implemented process to discu	ıss	
	they order and over	all was not good.			dietary concerns and progress	s	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155799	B. W	ING		01/20	/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	2			EST 14TH STREET		
ΔPERI∩N	N CARE MARION L	I.C.			N, IN 46953		
AI LINIOI	TOAKE MARION L			WALKIO			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	ļ	TAG	DEFICIENCY)		DATE
					with the residents, both in resi	dent	
	The clinical record for Resident F was reviewed on 1/19/22 at 2:29 p.m. Diagnoses included, but were				council and privately.		
					Facility staff were in-serviced		
		osis of liver, chronic atrial			facilities "Resident Rights" pol	-	
	fibrillation and chro	onic kidney disease.			A QA tool was created to ensu		
	A 1 1d 1	1 . 10/20/21 : 1: . 14			that all ordered menu items ar	е	
	_	dated 8/30/21, indicated the			received for each resident.		
		and symptoms of malnutrition			Random QA checks will be	,	
	related to end stage				completed three times a week		
	-	ventions included, but were			four weeks and then weekly.	ıne	
	not limited to, honor food preferences and provide				results of these audits will be	L. I.	
	diet as ordered.				reviewed in QA meeting month	-	
	3. During an interview on 1/20/22 at 9:10 a.m.,				for six months or until an average of 00% compliance or greater	_	
	Resident D indicated the food "sucked." He did				of 90% compliance or greater achieved for three consecutive		
		he ordered and the amounts			months. The QA Committee v		
		The only snacks he received			identify any trends or patterns		
		m his wife. Last night, he got a			make recommendations to rev		
	hotdog on a bun and				the plan of correction as indica		
	notdog on a oun and	a pea saiad.			the plan of correction as indica	aleu.	
	The clinical record	for Resident D was reviewed			4) Quality Assurance plans to		
		o.m. Diagnoses included, but			monitor facility performance to		
	-	dysphagia, protein-calorie			make sure that corrections are		
		lipidemia and hemiplegia.	achieved and are permanent:				
	, ,,	. 1 5					
	A health care plan,	dated 12/6/21, indicated			A QA tool was created to ensu	ıre	
	-	meals, snacks and fluids.			that all ordered menu items ar	е	
	_				received for each resident.		
	Review of a current	t health care plan, dated 8/23/17			Random QA checks will be		
		titled "Resident Rights,"			completed three times a week	for	
	provided by the Ad	ministrator on 1/19/22 at 11:25			four weeks and then weekly.		
	a.m., indicated the	following:			results of these audits will be		
	"Purpose: To prom	ote the exercise of rights for			reviewed in QA meeting montl	hly	
	each resident				for six months or until an avera	age	
	Exercise his or he	r rights			of 90% compliance or greater	is	
	Exercising rights	means the residents have			achieved for three months. Th	ne	
		age participation in meeting			QA Committee will identify any	/	
	care planning goals	as documented in the resident			trends or patterns and make		
		e plan are not interference or			recommendations to revise the	е	
	coercion "				plan of correction as indicated		I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155799		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 01/20/2022	
	PROVIDER OR SUPPLIER		614 W	ADDRESS, CITY, STATE, ZIP COD EST 14TH STREET ON, IN 46953	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F 0812 SS=E Bldg. 00	3.1-21(a)(1)  483.60(i)(1)(2) Food Procurement, Stors §483.60(i) Foods The facility must - §483.60(i)(1) - Procurement, state or local approved or consisted federal, state or local applicable State are gulations.  (ii) This provision facilities from using gardens, subject trapplicable safe graphicable safe gractices.  (iii) This provision from consuming for facility.  §483.60(i)(2) - Stors serve food in account of saccount	de food items obtained producers, subject to and local laws or does not prohibit or prevent g produce grown in facility o compliance with owing and food-handling does not preclude residents bods not procured by the ore, prepare, distribute and ordance with professional diservice safety. On, interview, and record failed to ensure food monitored, the kitchen was labeled and dated for 1 of 1	F 0812	F812 Food Procurement, Store/Prepare/Serve-Sanitary  1) Corrective actions which wi accomplished for those	
	Findings include: On 1/19/22 at 8:24	a.m., the Administrator		employees and residents found have been affected by the definition practice:	
		ous dietary manager ran all the		The facility conducted a deep	

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î ´		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155799	B. WI	ING		01/20/	2022
NAME OF F	PROVIDER OR SUPPLIEF	- !			ADDRESS, CITY, STATE, ZIP COD		
A DEDION	N CARE MARION I	1.0			EST 14TH STREET		
APERIO	N CARE MARION L	.LC		MARIO	N, IN 46953		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ff. Cook 1 was the only			cleaning of the kitchen. The	L -	
		left, but recently interviewed			dietary staff went through all the		
	for a new Dietary Manger. They currently had a total of 4 cooks, 3 of the 4 were still in training and 2 dietary aides were recently hired. They recently served meals to the residents from Fazolies,				food to ensure it had open or by dates, and discarded items		
					which were not dated properly		
					which were not dated properly		
	Kentucky Fried Chicken and Papa Johns due to				2) How will the facility identify	,	
	I -	er staff have also been			other residents having the		
	helping with meals.				potential to be affected by the		
					same deficient practice?		
	During an observation and interview on 1/19/22 at				·		
	9:05 a.m., Cook 1 indicated she did not write down				All residents have the potentia	al to	
	any temperatures from breakfast served today.				be affected by the alleged		
					deficiency.		
	_	the main facility kitchen with					
		at 9:05 a.m., the following was			3) The measures the facility v		
	observed:				take or systems the facility wil		
					alter to ensure that problems	will	
	_	sh can by the handwashing			be corrected or will not recur:		
	station had stains at	nd dirt covering the lid.			One to One sourcelling was	la	
	h The 6 human star	ve had a build up of burnt food			One to One counselling was o	ione	
	on each burner.	ve had a build up of built food			with cook 2 regarding hand hygiene and wearing a hairne	•	
	on each burner.				Dietary Staff were in-serviced		
	c. The backsplash I	behind the 6-burner stove had			facilities sanitation policy.	OH	
	a large area of great				Dietary Staff were in-serviced	on	
	<i>g</i>				facilities refrigerator and freez		
	d. Two catch-trays	under the 6-burner stove			temperature policy.		
	contained dried pas				Dietary Staff were in-serviced	on	
	_				facilities puree policy		
		Texas toast were in the freezer			Dietary Staff were in-serviced	on	
	with no open date o	r use by date.			deep cleaning schedule		
					Dietary Staff were in-serviced		
	_	ortillas with no open date or			facilities labeling and dating fo	ood	
	use by date.				policy		
					Dietary Staff were in-serviced		
		otdogs with no open date or			facilities ice handling and clea	ning	
	use by date.				policy.		
	h. A container of so	our cream with no open date or			4) Quality Assurance plans to	,	

DEPARTMENT OF HEALTH AND HUMAN SERVICES								
CENTERS FOR MEDICARE & MEDICAID SERVICES								
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155799	B. W	ING	_	01/20/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ST 14TH STREET		
APERIO	N CARE MARION L	LC		MARIO	N, IN 46953		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	use by date.				monitor facility performance to		
					make sure that corrections are	9	
	_	hicken breast with no open			achieved and are permanent:		
	date or use by date.						
	: A f	6			QA tools ere created to ensure	Э	
	use by date.	pen french fries with no date or			that dietary logs are being	d	
	use by date.				completed timely, food is date appropriately and cleaning is to		
	k The drain on the	floor under the tilt skillet had			conducted per policy and	Jenig	
					schedule. The QA tools will be	<b>A</b>	
grease and a build up of dried food.				completed three times a week			
1. The flour and sugar containers had stains and				four weeks and weekly. The			
food on the outside of the bins.				results of these audits will be			
1				reviewed in QA meeting month	hlv		
	During an interview	w with Cook 1, she indicated			for 6 months or until an averag	-	
	she was not aware there was a catch-tray under				90% compliance or greater is	•	
	the 6-burner stove.				achieved for three consecutive	е	
					months. The QA Committee v	vill	
	Cook 1 provided th	e following folders related to			identify any trends or patterns	and	
	kitchen maintenanc	e and/or food preparation on			make recommendations to rev	/ise	
	1/19/22 at 9:25 a.m				the plan of correction as indica	ated,	
		ented temperature obtained			then re-evaluated by the QA to	eam	
	from a meal was 11				for continued completion.		
		ented temperature for the					
		was completed on 10/29/21.					
		ented temperature for the					
	_	r was completed on 10/25/21.					
		ented temperature for the					
		s completed on 10/30/21.  Intention the state of the stat					
		e dish machine was completed					
	on 9/30/21.	aish machine was completed					
		nted sanitization log for the					
		completed on 9/30/21.					
	_	cleaning log for the ice					
	machine was provide						
	1						
	During an observat	ion and interview on 1/19/22 at					
		entered the kitchen without					
	wearing a hairnet o	r washing her hands. She then					
	<u> </u>						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2J3Z11 Facility ID: 012809

If continuation sheet Page 10 of 24

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155799		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 01/20/2022	
	ROVIDER OR SUPPLIER		614 WE	ADDRESS, CITY, STATE, ZIP COD EST 14TH STREET DN, IN 46953	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
PREFIX TAG	placed a bag in the oven. She indicated lunch in the refriger office and put a hair 10:31 a.m., Cook 1 the night shift cook 4 slices of white brought into a blender, amount hot water at together. She indice in the facility. The stainless steel bowl indicated she used a in the pureed food.  During an observating package of frozen of the open bag of ho freezer and Cook 1 out with the breakfaused a new box of homogened box of homo	facility refrigerator by the dishe just entered to put her rator. She then went into the rator on and interview on 1/19/22 at was preparing supper because was not coming in. She took rad and several hotdogs and She added an unknown and pureed the bread and meat rated they had 3 pureed meals meal was then placed in a rand placed in the warmer. She rator on on 1/19/22 at 11:00 a.m., the hicken was still in the freezer. It dogs were not found in the indicated she had thrown them rest trash. She indicated she rotdogs for supper, but an trades was noted on the rator of the same of the food recall the temperature of indicated she threw away the the bowl that had the she did not write the She found a food red the end and prior to placing rometer into the salad, Dietary	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE	ATE COMPLETION DATE
	from the office, she	1 brought her an alcohol pad cleaned the thermometer and ne bowl. The temperature read			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2J3Z11

Facility ID: 012809

If continuation sheet Page 11 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155799		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/20/2022	
	ROVIDER OR SUPPLIER		614 W	ADDRESS, CITY, STATE, ZIP COD EST 14TH STREET DN, IN 46953	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LLSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE COMPLETION
PREFIX TAG	between 40-60 degraround. Dietary Ai sure what the servir the temperature of the temperat	rees as the needle was moving de 3 indicated she was not ag temperature should be or he salad.  The thermometer from the office the tip into the container of with alcohol. The temperature was unsure if it read Fahrenheit ght the temperature should be so, but said the bowl was cold.  To a.m., the Administrator ing job descriptions for the dident of Operations (RVPO) able to find any orientation interary person. He was having mager come tomorrow to help etary staff.  To facility policy, dated 2020, and Freezer Temperatures," PO on 1/20/22 at 12:50 p.m.,	PREFIX TAG		
	temperatures on ten during each shift	nperature report logs daily,			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2J3Z11

Facility ID: 012809

If continuation sheet Page 12 of 24

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155799			JILDING	nstruction 00	(X3) DATE COMPL 01/20	ETED	
	PROVIDER OR SUPPLIER		•	614 WE	DDRESS, CITY, STATE, ZIP COD ST 14TH STREET N, IN 46953		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION on and freezer unitall cold		TAG	DEFICIENCY)		DATE
	_	F [Fahrenheit] or below0 F					
	or below for freeze	= =					
		selected and the temperature is					
		first check off the day, and the					
	food item(s) are > 4						
	validatedfood is discarded"  Review of a current facility policy, dated 2020,						
	titled "Labeling and Dating Foods (Date						
	Marking)," provided by the Regional Director of						
	Operations on 1/20/22 at 12:50 p.m., indicated the following:						
	Guideline: All foods stored will be properly						
	labeled according to the following guidelines.						
	Procedure:						
	_	r dry storage food items					
	Unopened cases of	=					
	Once a case is open						
	foodreceived into	the facility commercially prepared, dry					
	storage food items.						
	_	r refrigerator storage items					
	_	r freezer storage food items					
	-	opened, it will be re-dated with					
	the date"						
	Review of a current	t facility policy, dated 2020,					
		g and Cleaning" provided by					
		tor of Operations on 1/20/22 at					
	12:50 p.m., indicate						
		be stored and served to					
	residents in a sanita						
	6. Ice machine w sanitizer.	vill be wiped down daily with					
		l be emptied at least quarterly					
		aned with an approved					
	sanitizer"	11					
	This Federal tag rel	lates to Complaint IN00371088.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2J3Z11

Facility ID: 012809

If continuation sheet Page 13 of 24

PRINTED: 02/16/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER  155799	l í	JILDING	00	COMPL 01/20/	ETED
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 614 WEST 14TH STREET MARION, IN 46953				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
D 0000	3.1-21(i)(3)						
R 0000							
Bldg. 00	This visit was for the Investigation of Residential Complaint IN00371105. This visit included the Investigation of Nursing Home Complaint IN00371088.  Complaint IN00371005- Substantiated. State deficiency related to the allegations are cited at R0268, R0272 and R0273.  Complaint IN00371088- Substantiated. Federal/State deficiencies related to the allegations are cited at F684, F804 and F812.  Survey dates: January 19 and 20, 2022  Facility number: 012809		R 0000		Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. the facility respectfully request a desk review for these alleged deficient practices.		
	accordance with 410	ntial Findings are cited in DIAC 16.2-5.					
	Quality reveiw com	pleted on January 27, 2022.					
R 0268 Bldg. 00	(a) The facility sha available three (3) seven (7) days a v balanced distributi requirements.	nal Services - Deficiency all provide, arrange, or make well-planned meals a day, week that provide a on of the daily nutritional and record review, the facility	R 02	240	R268 Food and Nutritional		02/02/2022
	failed to ensure thre	e well-planned meals a day,  c were served and palatable	K U.	<b>400</b>	Services		02/03/2022

State Form Event ID: 2J3Z11 Facility ID: 012809 If continuation sheet Page 14 of 24

PRINTED: 02/16/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  155799		ľ í	JILDING	ONSTRUCTION  00	(X3) DATE COMPL 01/20/	ETED	
	PROVIDER OR SUPPLIER			614 WE	ADDRESS, CITY, STATE, ZIP COD EST 14TH STREET N, IN 46953		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX	FIX  PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION
TAG	for overall quality of	of taste for 1 of 3 residents d quality. (Resident J)		TAG	Corrective actions which w accomplished for those employees and residents four	rill be	DATE
	Findings include:				have been affected by the def practice:		
	Resident J indicated day from the facilit as 2:00 p.m. They tray a few times. T at 6:00 p.m. before does not receive what The other day, she ordered them in the them. Resident J was menu for that day, I room from the preventles as an option. The clinical record 1/19/22 at 9:40 a.m. not limited to, hyper dysphagia and anergeness.	y on 1/19/22 at 8:55 a.m., If she only received one meal a y. It has been delivered as late had forgotten to bring her a the other evening, the aides left supper was even served. She hat she orders from the menu. ordered egg rolls and has repast but has never received trast told they were not on the but had a meal ticket in her rious day with vegetable egg The food is "pitiful."  for Resident J was reviewed on . Diagnoses included, but were ertension, diabetes mellitus, mia.  determined the determined of the content of the co			Dietary staff discussed the facilities menu with Resident well as meal preferences. Die staff will ensure Resident J receives appropriate meals ting.  2) Ho will the facility identify or residents having the potential be affected by the same deficit practice?  Facility conducted a survey of other residents regarding received a survey of other residents regarding received and the same deficit practice?  Facility conducted a survey of other residents regarding received and the same deficit practice.  3) The measures the facility with take or systems the facility will alter to ensure that problems of the same deficit practice.	etary nely. other to ient eiving and d. vill	
	A health care plan, 8/21/21, indicated to included, but were serve a regular diet not available.  Review of a current and revised 1/4/19, provided by the Ada.m., indicated the serve a regular diet not available.	dated 6/29/19 and revised he resident had a nutritional diabetes. Interventions not limited to, provide and and offer alternative if entree  t health care plan, dated 8/23/17 titled "Resident Rights," ministrator on 1/19/22 at 11:25			be corrected or will not recur:  Facility staff were in-serviced. Facilities Residents Rights Po Dietary staff were in-serviced regarding mealtimes and follomeal tickets.  A Quality Assurance (QA) too was created to ensure that all ordered menu items were recefor each resident, and that it is served at appropriate time. To QA tool will be completed threatimes a week for 12 weeks and then re-evaluated by the QA to	on licy. wing I eived s he ee	

State Form Event ID: 2J3Z11 Facility ID: 012809 If continuation sheet Page 15 of 24

PRINTED: 02/16/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155799		A. BUILDING 00  B. WING			COMPLETED 01/20/2022		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 614 WEST 14TH STREET MARION, IN 46953				
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	autonomyencoura care planning goals assessment and care coercion."	r rights means the residents have age participation in meeting as documented in the resident plan are not interference or ates to Complaint IN00371105.			for continued completion.  4) Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent:  A QA tool was created to ensurance to make sure that corrections are achieved and are permanent:  A QA tool was created to ensurance that all ordered menu items are received for each resident and it is served at appropriate time. The QA tool will be completed three times a week for four were and then weekly. The results of these audits will be reviewed in QA meeting monthly for six months or until an average of Scompliance or greater is achieved for three consecutive months. QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	re ethat eks of n e00% ved the	
R 0272 Bldg. 00		al Services - Deficiency e served at a safe and					
	Based on observation review, the facility for temperatures were operatures to serving food	on, interview and record  ailed to ensure food  btained and/or documented  This deficiency had the  of 6 residents who received	R 0272	2	R272 Food and Nutritional Services 1) Corrective actions which wi accomplished for those employees and residents found have been affected by the defin practice:	d to	02/03/2022
	-	a.m., the Administrator			Facility Dietary staff were in-serviced on maintaining		

State Form Event ID: 2J3Z11 Facility ID: 012809 If continuation sheet Page 16 of 24

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155799	B. WI	NG		01/20/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER				ST 14TH STREET		
APFRION	N CARE MARION L	IC			N, IN 46953		
	T		1	<u> </u>	, 10000		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	us dietary manager ran all the			temperature logs, and logs are	9	
		ff. Cook 1 was the only left, but recently interviewed			being maintained.		
		Ianger. They currently had a			2)How will the facility identify a	other	
	_	f the 4 were still in training and			2)How will the facility identify or residents having the potential		
	2 dietary aides were recently hired. They recently				be affected by the same defici		
					practice?	OIIL	
	served meals to the residents from Fazolies, Kentucky Fried Chicken and Papa Johns due to				praduoc:		
	staffing issues. Other staff have also been				All 6 of the facilities residents I	had	
	helping with meals.				potential to be affected by the		
	nciping with ineals.				alleged deficiency, as identifie	d by	
	During an observati	on and interview on 1/19/22 at			the 2567.	,	
	_	ndicated she did not write down					
	any temperatures from breakfast served today.				3) The measures the facility w	/ill	
					take or systems the facility will		
		e following folders related to			alter to ensure that problems v		
	kitchen maintenanc 1/19/22 at 9:25 a.m	e and/or food preparation on			be corrected or will not recur:		
		: nted temperature obtained			Dietary Staff wore in consided	on	
	from a meal was 11	-			Dietary Staff were in-serviced facilities poly regarding	OH	
		nted temperature for the			documentation of food		
		was completed on 10/29/21.			temperatures.		
	_	nted temperature for the			Dietary Staff were in-serviced	on	
		r was completed on 10/25/21.			facilities sanitation policy.		
		nted temperature for the			Dietary Staff were in-serviced	on	
		completed on 10/30/21.			facilities Refrigerator and Free		
		nted temperature and/or			Temperature Policy.		
	maintenance for the	dish machine was completed			QA tools were created to ensu	ire	
	on 9/30/21.				logs are maintained for food,		
	f. The last document	nted sanitization log for the			refrigerator, freezer and		
		ompleted on 9/30/21.			dishwasher temperatures. The		
		cleaning log for the ice			QA tool will be completed thre		
	machine was provid	led.			times a week for one month ar	nd	
					weekly there after.		
		a.m., Dietary Aide 3 was					
		rinks and foam bowels with a			4) Quality Assurance plans to		
		d Jell-O dessert in the food			monitor facility performance to		
		le to recall the temperature of			make sure that corrections are	)	
		indicated she threw away the			achieved and are permanent:		
	1011 from the top of	the bowel that had the					

State Form Event ID: 2J3Z11 Facility ID: 012809 If continuation sheet Page 17 of 24

PRINTED: 02/16/2022 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155799	A. BUILDING B. WING	00	COMPLETED 01/20/2022
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD EST 14TH STREET	
APERIO	N CARE MARION L	LC		N, IN 46953	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	temperature down. thermometer, touche the end of the therm Aide 3 was asked to thermometer. Cook from the office, she place the end into the read between 40-60 moving around. Die not sure what the se or the temperature of Cook 1 found anoth and quickly placed to without cleaning offi read 55.2. Cook 1 vo or Celsius and though less than 32 degrees Cook 1 was going to salad could be served On 1/19/22 at 11:25 provided the follow dietary staff: a. Cook 1, dated 9/ b. Cook 7, dated 1/d. C. Cook 2, dated 1/d. Dietary Aide 4, de e. Dietary Aide 3, d  During an interview Regional Vice Presi indicated he was un check-list for any di another Dietary Mai orient the current di  Review of a current	ed the end and prior to placing someter into the salad, Dietary of stop and clean the an alcohol pad cleaned the thermometer and the bowel. The temperature degrees as the needle was etary Aide 3 indicated she was riving temperature should be of the salad.  The temperature should be of the tip into the container of with alcohol. The temperature was unsure if it read Fahrenheit ght the temperature should be of the salad was discarded.  The salad was discarded.		QA tools were created to ensulogs are maintained for food, refrigerator, freezer and dishwasher temperatures. The QA tool will be completed threatimes a week for four weeks a weekly there after. The result these audits will be reviewed QA meetings monthly for six months or until an average of compliance or greater is achiefor three consecutive months. QA Committee will identify an trends or patterns and make recommendations to revise the plan of correction as indicated.	eee and so of so o

State Form Event ID: 2J3Z11 Facility ID: 012809 If continuation sheet Page 18 of 24

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155799		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/20/2022		
	ROVIDER OR SUPPLIER		614 WI	ADDRESS, CITY, STATE, ZIP COD EST 14TH STREET DN, IN 46953	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R 0273 Bldg. 00	indicated the follow "Guidelines: To enteresh  Procedure:  1. Dining Services of temperatures on all refrigerators and free temperatures on tem during each shift  2. Each refrigeration storage units are 41 or below for freezer a. A food itemis so taken. If this is not food item(s) are > 4 validatedfood is defined in a control of the storage and nutrition (f) All food preparate (excluding areas in maintained in according and according and standards, including Based on observation review, the facility is serve food in a sanitare residents who receive kitchen.  Findings include:  On 1/19/22 at 8:24 a indicated the previoon other dietary staff of dietary staff person	will be responsible for taking kitchen and nourishment room ezers, and recording aperature report logs daily,  n and freezer unitall cold  F [Fahrenheit] or below0 F s elected and the temperature is first check off the day, and the 1 F and cannot be iscarded"  ates to Complaint IN00371105.  1(f) hal Services - Deficiency ation and serving areas in residents ' units) are ordance with state and d safe food handling	R 0273	R273 Food and Nutritional Services  1) Corrective actions which waccomplished for those employees and residents four have been affected by the def practice:  The facility conducted a deep cleaning of the kitchen. The dietary staff went through all to food to ensure it had open or	nd to icient he

State Form Event ID: 2J3Z11 Facility ID: 012809 If continuation sheet Page 19 of 24

PRINTED: 02/16/2022 FORM APPROVED OMB NO. 0938-039

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155799			UILDING	00 00	COMPL: 01/20/	ETED
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD EST 14TH STREET		
APERIO	N CARE MARION L	LC			N, IN 46953		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION of the 4 were still in training and		TAG	by dates, and discarded items		DATE
		e recently hired. They recently			which were not dated properly		
	-	residents from Fazolies,					
		icken and Papa Johns due to			2) How will the facility identify	,	
		ner staff have also been			other residents having the		
	helping with meals.				potential to be affected by the same deficient practice?		
	During an observation and interview on 1/19/22 at				Same delicient practice?		
	9:05 a.m., Cook 1 indicated she did not write down				All six of the facilities residents	3	
	any temperatures from breakfast served today.				had potential to be affected by	the	
					alleged deficiency, as identifie	d by	
		the main facility kitchen with			the 2567.		
	observed:	at 9:05 a.m., the following was			3) the measures the facility w	ill	
	observed.				take or systems the facility wil		
	a. The top of the tra	sh can by the handwashing			alter to ensure that problems v		
	station had stains ar	nd dirt covering the lid.			be corrected or will not recur:		
	b. The 6-burner sto	ve had a build up of burnt food			One to one counselling was d	one	
	on each burner.				with cook 2 regarding hand		
					hygiene and wearing a hairne		
	c. The backsplash to a large area of great	behind the 6-burner stove had			Dietary Staff were in-serviced	on	
	a large area or great	se.			facilities sanitation policy.  Dietary Staff were in-serviced	on	
	d. 2 catch-trays und	der the 6-burner stove			facilities refrigerator and freez		
	contained dried pas				temperature policy.		
					Dietary Staff were in-serviced	on	
		s toast were in the freezer with			facilities puree policy.		
	no open date or use	by date.			Dietary Staff were in-serviced deep cleaning schedule.	on	
	f. A bag of frozen to	ortillas with no open date or			Dietary Staff were in-service of	n l	
	use by date.	•			facilities labeling and dating fo		
					policy.		
		notdogs with no open date or			Dietary Staff were in-serviced		
	use by date.				facilities ice handling and clea	ning	
	h. A container of so	our cream with no open date or			policy.		
	use by date.	-					
	i. A frozen bag of c	hicken breast with no open					

State Form Event ID: 2J3Z11 Facility ID: 012809 If continuation sheet Page 20 of 24

PRINTED: 02/16/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155799		l í	JILDING	00	COMPL 01/20	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 614 WEST 14TH STREET MARION, IN 46953				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE	
	date or use by date.  j. A frozen bag of o use by date.  k. The drain on the grease and a build use by date.  l. The flour and sug food on the outside  During an interview she was not aware to the 6-burner stove.  Cook 1 provided the kitchen maintenance 1/19/22 at 9:25 a.m.  a. The last docume from a meal was 11 b. The last docume walk-in refrigerator c. The last docume walk-in refrigerator d. The last docume walk-in freezer wase. The last docume maintenance for the on 9/30/21.  f. The last docume pots and pans was cong. No record of the machine was provided.	pen french fries with no date or  floor under the tilt skillet had up of dried food.  gar containers had stains and of the bins.  with Cook 1, she indicated here was a catch-tray under  e following folders related to e and/or food preparation on the interval of the end of the was completed on 10/29/21.  Inted temperature for the end was completed on 10/25/21.  Inted temperature for the end of the end of the completed on 10/30/21.  Inted temperature and/or end of the dish machine was completed on 10/30/21.  Inted temperature and/or end of the completed on 9/30/21.  Inted sanitization log for the completed on 9/30/21.  Icleaning log for the ice			CROSS-REFERENCED TO THE APPROPRIA	TE	DATE
	10:10 a.m., Cook 2 wearing a hairnet of placed a bag in the oven. She indicated	entered the kitchen without r washing her hands. She then facility refrigerator by the d she just entered to put her rator. She then went into the					

State Form Event ID: 2J3Z11 Facility ID: 012809 If continuation sheet Page 21 of 24

PRINTED: 02/16/2022 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155799		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY  COMPLETED  01/20/2022	
	PROVIDER OR SUPPLIE		614 W	ADDRESS, CITY, STATE, ZIP C EST 14TH STREET DN, IN 46953	OD	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE  NCY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
1710	office and put a ha		17.0			DATE
	10:31 a.m., Cook the night shift cool 4 slices of white brut into a blender. amount hot water a together. She indirin the facility. The stainless steel bow indicated she used in the pureed food.  During an observation package of frozen. The open bag of he freezer and Cook 1 out with the breakt used a new box of unopened box of his preptable.  On 1/19/22 at 11:0 placing trays with mandarin orange a cart. She was unall the Jell-O salad an foil from the top of temperature on it. temperature down, thermometer, touch the end of the thermometer. Coof from the office, shiplace the end into read between 40-6 moving around. Direction of the put into the policy of the place the end into read between 40-6 moving around.	tion on 1/19/22 at 11:00 a.m., the chicken was still in the freezer. otdogs were not found in the indicated she had thrown them fast trash. She indicated she hotdogs for supper, but an otdogs was noted on the 1/2 a.m., Dietary Aide 3 was drinks and foam bowels with a not Jell-O dessert in the food ole to recall the temperature of d indicated she threw away the f the bowel that had the She did not write the				

State Form Event ID: 2J3Z11 Facility ID: 012809 If continuation sheet Page 22 of 24

PRINTED: 02/16/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PRO		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED	
		155799	B. WI	NG		01/20/	/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIER	R			ST 14TH STREET			
APFRIO	N CARE MARION L	I C			N, IN 46953			
	Г			L	11, 111 10000			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	or the temperature of	of the salad.						
	Cook 1 found anoth	on thomas another from the office						
		her thermometer from the office the tip into the container						
		-						
	without cleaning off with alcohol. The temperature read 55.2. Cook 1 was unsure if it read Fahrenheit							
		ght the temperature should be						
		s, but said the bowl was cold.						
	ı	o ask the Administrator if the						
		ed. The salad was discarded.						
	saida coula oc sei vi	ed. The salad was discarded.						
	On 1/19/22 at 11:25	5 a.m., the Administrator						
	provided the following job descriptions for the							
	dietary staff:							
	a. Cook 1, dated 9/18/21.							
	b. Cook 7, dated 1/							
	c. Cook 2, dated 1/							
	d. Dietary Aide 4, d							
	e. Dietary Aide 3, d							
	During an interview	on 1/19/22 at 1:49 p.m., the						
		ident of Operations (RVPO)						
	indicated he was un	able to find any orientation						
	check-list for any d	ietary person. He was having						
	another Dietary Ma	nager come tomorrow to help						
	orient the current di	ietary staff.						
		t facility policy, dated 2020,						
		and Freezer Temperatures,"						
	l - ·	PO on 1/20/22 at 12:50 p.m.,						
	indicated the follow	_						
		sure all perishable foods stay						
	fresh							
	Procedure:							
		will be responsible for taking						
		kitchen and nourishment room						
		eezers, and recording						
	_	nperature report logs daily,						
	during each shift							
	2. Each refrigeration	on and freezer unitall cold						

State Form Event ID: 2J3Z11 Facility ID: 012809 If continuation sheet Page 23 of 24

PRINTED: 02/16/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155799	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 01/20/2022	
NAME OF PROVIDER OR SUPPLIER  APERION CARE MARION LLC				STREET ADDRESS, CITY, STATE, ZIP COD 614 WEST 14TH STREET MARION, IN 46953				
(X4) ID PREFIX TAG	storage units are 41 or below for freeze a. A food itemis staken. If this is not food item(s) are > 4 validatedfood is of	relected and the temperature is first check off the day, and the H F and cannot be discarded"		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	titled "Labeling and Marking)," provided Operations on 1/20 following: Guideline: All food labeled according to Procedure:  1. Date marking food Unopened cases of Once a case is oper foodreceived into Expiration dates on storage food items.  2. Date marking food items.  3. Date marking food items.  4. Date marking food items.  5. Date marking food items.  6. Date marking food items.  7. Date marking food items.  8. Date marking food items.	the facility commercially prepared, dry refrigerator storage items refreezer storage food items opened, it will be re-dated with						
	titled "Ice Handling the Regional Direc 12:50 p.m., indicat Guideline: Ice will residents in a sanita6. Ice machine was sanitizer.  7. Ice machine will and thoroughly cleas sanitizer"	be stored and served to						

State Form Event ID: 2J3Z11 Facility ID: 012809 If continuation sheet Page 24 of 24