STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155799	B. WING		12/16/2024
			CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>
NAME OF I	PROVIDER OR SUPPLIE	ER		EST 14TH STREET	
APERIO	N CARE MARION	IIC		N, IN 46953	
	T			I	ı
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
F 0000					
Plda 00					
Bldg. 00	This visit was for t	the Investigation of Complaints	E 0000		
		-	F 0000		
	IN00449266, IN00448992, and IN00448904.				
	Complaint IN0044	19266 - Federal/State deficiencies			
	_	ations are cited at F609 and			
	R090.				
	Complaint IN0044	18992 - Federal/State deficiencies			
	_	ations are cited at F812 and			
	R273.				
	_	18904 - Federal/State deficiencies			
	_	ations are cited at F812 and			
	R273.				
	Survey dates: Dec	ember 11, 12, 13 and 16, 2024			
	F 77. 1 0	12000			
	Facility number: 0 Provider number:				
	AIM number: 201				
	Allyl humber: 201	130380			
	Census Bed Type:				
	SNF: 7				
	SNF/NF: 52				
	Residential: 12				
	Total: 71				
	Census Payor Typ	oe e			
	Medicare: 7				
	Medicaid: 40				
	Other: 12				
	Total: 59				
		reflect State Findings cited in			
	accordance with 4	10 IAC 16.2-3.1.			
		1.15			
	Quality review con	mpleted December 23, 2024.			
				num -	
LABORATOF	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	SIGNATURE	TITLE	(X6) DATE
Tamera Sl	nirels		FD		01/10/2025

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.

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f ´		(X2) M				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU				ETED
		155799	B. W	ING		12/16/	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L			EST 14TH STREET		
ADEDION	N CARE MARION L	I.C			N, IN 46953		
AI LINIOI	V CAIL WAITION L			WAN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0609	483.12(b)(5)(i)(A)(B)(c)(1)(4)					
SS=D	Reporting of Alleg						
Bldg. 00	Bldg. 00						
Ü	Based on record rev	view and interview, the facility	F 00	509	Tag number: F 609		01/10/2025
		sident to resident altercation to		30)	I. What corrective action(s) will be accomplished for those		01/10/2020
	_	Resident F and Resident G)					
					residents found to have been		
	Findings include:				affected by the deficient practi	ce;	
	Č				Interviews and investigation w		
	During an interview	on 12/16/24 at 12:31 p.m.,			facility staff and residents were		
		d she was hit by another			conducted related to the follow		
	resident in the chest	t. Resident F indicated she			abuse allegations: Resident F	•	
	was attempting to en	nter the dining room and			and Resident G on or about		
		cking the entry way. She			10/24/2024		
	asked Resident G to	move and the other resident					
	became aggressive.	Resident F indicated she had					
		t as a result of being hit.			II. How other residents ha	ving	
	Resident F indicated	d she hit Resident G in			the potential to be affected by	the	
	response and there v	were staff witnesses to the			same deficient practice will be		
	incident.				identified and what corrective		
					action(s) will be taken; Reside	ents	
	Resident F's residen	itial clinical record was			appropriate for interview (BIM	S 13	
	reviewed on 12/16/2	24 at 1:16 p.m. The clinical			or higher) were interviewed		
	record lacked indica	ation of behavioral concerns.			regarding abuse by Social Sei	rvice	
					and or the D.O.N. No allegation	ns	
		g home clinical record was			of abuse were made.		
		24 at 1:25 p.m. Diagnoses					
	included depression	_					
		order, and hypertension. The			III. What measures will be	put	
		ry of verbally aggressive			into place and what systemic		
	behaviors.				changes will be made to ensu		
					that the deficient practice does		
		on 12/16/24 at 2:19 p.m., the			recur; Staff were re-educated		
		Vice President of Operations			types of abuse and guidelines		
		nt was not reported to the			immediate reporting of abuse	to	
	State Agency and it	should have been.			Administrator.		
					IV. How the corrective action(s	•	
		ited 12/17/21, titled "Abuse			will be monitored to ensure the		
	_	orting-Indiana," provided by			deficient practice will not recui	r	
the Corporate Regional Vice President of				i.e., what quality assurance			

AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155799		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/16/2024	
	ROVIDER OR SUPPLIER		614 WE	ADDRESS, CITY, STATE, ZIP COD EST 14TH STREET 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
	Allegations: When a exploitation, neglect misappropriation of occurred, the resided Department of Public electronic reporting the Gateway is not five by telephone or fax. be informed that an neglect, exploitation misappropriation of and being investigat Informing Local Lashall also contact locauthorities (i.e. telepin the following situs Physical abuse invo on a resident by ano situations where the dementia or develop	ing Initial Reporting of an allegation of abuse, t, mistreatment or resident property has nt's representative and the ic Health shall be informed by into the IDOH Gateway, or if functioning, will be reported Department of Health shall occurrence of potential abuse, t, mistreatment or property has been reported ed. w Enforcement. The facility cal law enforcement phoning 911 where available)		program will be put into place; Abuse interviews will be conducted by Social Service/designee on at least 8 residents per week x 4 weeks, then 3 residents per week x 4 weeks, then 5 residents per Grievances will be reviewed at least 5 times per week by the to ensure potential abuse allegations are identified and reported to the Administrator at ISDH as appropriate and a thorough investigation is completed. The results of these audits will reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achie x3 consecutive months. The C Committee will identify any trea or patterns and make recommendations to revise the plan of correction as indicated	t IDT and be ved QA nds
F 0812 SS=F Bldg. 00	Based on record rev observation, the fac- kitchen food storage This deficient practi	e/Prepare/Serve-Sanitary iew and interview and ility failed to ensure sanitary and handling conditions. ce had the potential to effect idents who received their meals when.	F 0812	Tag number: F 812 I. What corrective actions will be accomplished for those residents found to have been affected by the deficient practical All food items listed on the 256 were discarded. During the to all areas mentioned in 2567, we cleaned and sanitized.	ce; 57 ur,

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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	ETED
		155799	B. W	ING		12/16/	2024
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			EST 14TH STREET		
 APFRI∩I	N CARE MARION L	I.C.			N, IN 46953		
, " LI (101	,			1477 (1 (1)	, 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
	_	ur with Cook 1, on 12/11/24 at					
	10:10 a.m., the follo	owing concerns were observed:			l., ., ., ., ., ., .		
	. Am array 1 C	oncomin o him containin-			II. How other residents ha	-	
		sugar in a bin containing			the potential to be affected by		
	unknown particles of and trash in the bottom of				same deficient practice will be	!	
	the bin.	vls, and plates stored upright,			identified and what corrective		
	_				action(s) will be taken; All	.+	
	exposing the eating surfaces. c. A cart holding clean dishes visibly soiled with				residents receiving an oral die have the potential to be affect		
	dried food and spla	•			i nave the potential to be affecti	cu.	
	d. A bucket with dirty mop water and a mop						
	leaning against the clean dishes rack.				III. What measures will be	nut	
	e. A cleaning bucket with used cleaning cloths				into place and what systemic	Par	
	stored under the over	_			changes will be made to ensu	re	
		itensils on the preparation			that the deficient practice does		
	table.	1 1			recur; All dietary staff were		
		nd trash over the surface of the			educated on food storage,		
	floor.				labeling, cleaning and sanitation	on	
	h. An open sleeve	of bread on the preparation			by the consulting firm On-Tray		
	_	date on the packaging.			Cleaning schedules have been		
	_	vered box of cream of wheat			updated and assigned to each		
	with no open date of	on the packaging.			shift.		
	j. The three comp	artment sink with dried food at					
	the bottom and arou	and the drain.					
	k. A cart with used	d breakfast dishes standing			IV. How the corrective		
	next to the clean dis				action(s) will be monitored to		
		dated bag of stuffing.			ensure the deficient practice w	vill	
		oottle of concentrated lemon			not recur i.e., what quality		
	"	/19, with no open date in the			assurance program will be put		
	dry storage area.				place; Kitchen food storage a		
		g of egg noodles received on			will be audited at least 5 times	а	
	10/15, with no oper				week by the Dietary		
		ttle of syrup with no open			Manager/designee x 4 weeks,		
	date.				then 3 times a week by 4 week	ks	
		rkey breast lunch meat, dated			and then weekly until 100%		
	as received on 12/10, with no open date, wrapped				compliance is achieved for 3		
	in foil.				consecutive months for dating	and	
		ped lettuce with no open date.			labeling food items.		
	_	drain with dried spillage, trash					
	debris, and bits of food.				The Dietary Manager/designe	e will	

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	COMPLETED
		155799	B. W	ING	<u> </u>	12/16/2024
		1		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>
NAME OF I	PROVIDER OR SUPPLIEI	3			EST 14TH STREET	
ADEDIO	N CARE MARION L	1.0			N, IN 46953	
AFERIO	N CARE WARION I			WARIO		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	JST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY	DATE
		of equipment and preparation			collect daily cleaning check of	
	tables were soiled v				sheets/cleaning schedules, to	
	t. The trash container placed near the food				assure that the cleaning and	
	preparation table with no lid.				sanitizing is done and comple	
	u. The ceiling vent over the food preparation table				after each shift, by auditing th	e
	with visible dark black/brown matter hanging from				areas at least 5 times a week	
	vent.				weeks, then 3 times a week x	
					weeks and then weekly until 1	
	During a tour of the main dining room the				compliance is achieved for 30	
	following was obse	erved:			consecutive	
					months.	
	a. Counter tops with visible dried spillage.					
	b. Floor with trash and food.					
	c. Drink machines soiled with dark brown dried				The results of these audits wil	
	substance.				reviewed in Quality Assurance	
		ith dried dark brown			Meeting monthly x6 months o	r
	substance.				until an average of 90%	
	_	with dried substance on lids			compliance or greater is achie	
	and unknown debri				x3 consecutive months. The	
	f. Warming table	left on and hot to touch.			Committee will identify any tre	ends
					or patterns and make	
	_	ook 1 indicated the warming			recommendations to revise th	
		used since the evening meal			plan of correction as indicated	
	1 ~	he warming tables should have				
	been turned off after	er use.				
	Danie					
	_	v on 12/11/24 at 10:10 a.m.,				
		he kitchen should have been				
		shift. The facility did not have				
	_	e. Cook 1 indicated staff tried				
		they saw something that				
	time the kitchen ha	Cook 1 did not know the last				
	ume me kitchen na	u been cleaned.				
	During an interview	v on 12/12/24 at 12:15 p.m.,				
		cated she tried to wash out the				
	1					
	cart if she was working. They just tried to trade off on what needed to be done. Whomever					
		would mop the floor. There				
	was no deep cleaning	ng schedule. There used to be				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155799	B. W	ING		12/16	/2024
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			ST 14TH STREET		
A DEDION	N CARE MARION L	1.0			N, IN 46953		
APERIO	N CARE MARION L	.LC		WARIO	N, IN 40955		
(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	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	one, but the last ma	nager took it down and never					
	replaced it.						
	1	v on 12/13/24 at 10:14 a.m.,					
		fter each meal, the kitchenette					
	I -	ere wiped down and the floors					
	mopped.						
		10/10/01					
	1	y on 12/13/24 at 1:00 p.m., the					
		Dietary Consultant indicated					
		eded more education on food					
	_	ng the kitchen. The facility					
		ng for a new food service					
	kitchen had been cl	not know the last time the					
	kitchen had been ci	eaned.					
	A aumant policy de	ated 2020, titled "Handling					
		s provided by Administrator on					
		m The policy indicated the					
	_	eline: Leftover food will be					
	_	ooled, and stored to ensure					
		l waste 4. Leftover foods					
	· ·	rator shall be wrapped, dated,					
	_	by date that is no more than 72					
		of first use. 5. Refrigerator					
		ond 72 hours shall be					
	discarded"						
	A current policy, da	ated 2020, titled "Cleaning					
	Rotation" was prov	ided by Administrator on					
	12/12/24 at 1:33 p.r	n The policy indicated the					
	following:						
	"Guidelines: Equip	ment and utensils will be					
	cleaned and sanitize	ed according to the following					
	guidelines, or manu	facture's instructions.					
		cleaned and sanitized after					
		ables and counters 2. Items					
	cleaned daily: stove	topKitchen and dining room					
	floorsMop and n	nop buckets, Steam table, Hand					
	washing sink, Food	carts, Pot and pan sink3.					

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Event ID:

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Facility ID: 012809

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155799		A. BUILDING 00 B. WING			COMPLETED 12/16/2024		
	ROVIDER OR SUPPLIER			614 WES	DDRESS, CITY, STATE, ZIP COD ST 14TH STREET I, IN 46953		
(X4) ID PREFIX TAG	(EACH DEFICIEN		P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	Items cleaned weekly: filters, Coffee machine4. Items cleaned monthly:Ingredient bins Walls" A current policy, dated 2020, titled "Food Storage (Dry, Refrigerated, and Frozen)," provided by Administrator on 12/12/24 at 1:33 p.m., indicated the following: " Procedure: 1. General storage guidelines to be followed: a. All food items will be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded" This citation relates to Complaint IN00448904 and IN00448992. 3.1-21(i)(3)		R 000	TAG	CROSS-REFERENCED TO THE APPROPRIAT	TE	
	Complaint IN00449 related to the allegar F609. Complaint IN00448 related to the allegar F812. Complaint IN00448 related to the allegar F812.	148992, and IN00448904. 266 - Federal/State deficiencies tions are cited at R090 and 1992 - Federal/State deficiencies tions are cited at R273 and 1904 - Federal/State deficiencies tions are cited at R273 and 1904 - Federal/State deficiencies tions are cited at R273 and 1904 - Federal/State deficiencies tions are cited at R273 and					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155799		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/16/2024		
	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 12		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
R 0090 Bldg. 00	These State Resider accordance with 410 Quality review com 410 IAC 16.2-5-1. Administration and	ntial Findings are cited in 0 IAC 16.2-5. pleted December 23, 2024. 3(g)(1-6) d Management - Deficiency	D.O.	000	Townshow B0000		01/10/2025
	failed to report a resaltercation to the St Resident G) Findings include: During an interview Resident F indicated resident in the chest was attempting to e Resident G was blo asked Resident G to became aggressive. a bruise on her ches Resident F indicated response and there wincident. Resident F's resident reviewed on 12/16/2 record lacked indicated reviewed on 12/16/2 included depression schizoaffective discontinuous residents of the series	riew and interview, the facility sident to resident physical ate Agency. (Resident F and on 12/16/24 at 12:31 p.m., d she was hit by another. Resident F indicated she nter the dining room and cking the entry way. She o move and the other resident Resident F indicated she had t as a result of being hit. d she hit Resident G in were staff witnesses to the atial clinical record was 24 at 1:16 p.m. The clinical ation of behavioral concerns. In the clinical record was 24 at 1:25 p.m. Diagnoses and dementia, anxiety, and reder, and hypertension. The rey of verbally aggressive	RO	090	I. What corrective action will be accomplished for those residents found to have been affected by the deficient pract Interviews and investigation will staff and residents were conducted related to the follow abuse allegations: Resident Frank and Resident G on or about 10/24/2024 II. How other residents has the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken; Resident propriate for interview (BIM or higher) were interviewed regarding abuse by Social Se and or the D.O.N. No allegation of abuse were made. III. What measures will be into place and what systemic changes will be made to ensurthat the deficient practice doe recur; Staff were re-educated.	ice; vith e ving the ents S 13 rvice ons	01/10/2025

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PRINTED: 01/23/2025 FORM APPROVED OMB NO. 0938-039

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155799		A. BUILDING B. WING	00 00	COMPLETED 12/16/2024
	ROVIDER OR SUPPLIER		614 WE	ADDRESS, CITY, STATE, ZIP COD EST 14TH STREET N, IN 46953	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENCE REGULATORY OR During an interview Corporate Regional indicated the incider State Agency and it A current policy, da Prevention and Report the Corporate Region Operations indicated " External Report Allegations: When a exploitation, neglect misappropriation of occurred, the resider Department of Public electronic reporting the Gateway is not for by telephone or fax. be informed that an neglect, exploitation misappropriation of and being investigat Enforcement. The falaw enforcement aut where available) in Physical abuse invo on a resident by ano situations where the dementia or develop	ETATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION on 12/16/24 at 2:19 p.m., the Vice President of Operations at was not reported to the should have been. ted 12/17/21, titled "Abuse orting-Indiana," provided by onal Vice President of at the following: ing Initial Reporting of an allegation of abuse, at, mistreatment or resident property has at's representative and the at Health shall be informed by into the IDOH Gateway, or if functioning, will be reported Department of Health shall occurrence of potential abuse,	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) types of abuse and guidelines immediate reporting of abuse Administrator. IV. How the corrective action(swill be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Abuse interviews will be conducted by Social Service/designee on at least residents per week x 4 weeks, then 3 residents per week x 4 weeks, then 5 residents per Grievances will be reviewed a least 5 times per week by the to ensure potential abuse allegations are identified and reported to the Administrator at ISDH as appropriate and a thorough investigation is completed. The results of these audits will reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achied x3 consecutive months. The Committee will identify any tree or patterns and make	for to (S)
R 0273 Bldg. 00		al Services - Deficiency	D 0272	recommendations to revise the plan of correction as indicated	
	Based on record rev	iew and interview and	R 0273	Tag number: R 0273	01/10/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155799	B. W	NG	_	12/16/	/2024
				_			
NAME OF 1	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					EST 14TH STREET		
APERIO	N CARE MARION L	.LC		MARIO	N, IN 46953		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	observation, the fac	cility failed to ensure sanitary			I. What corrective action	(s)	
	kitchen food storag	e and handling conditions.			will be accomplished for those		
	This deficient pract	ice had the potential to effect			residents found to have been		
	12 of 12 facility residents who received their meals				affected by the deficient practi	ce;	
	from the facility kit	chen.			All food items listed on the 256		
					were discarded. During the to	ur,	
	Findings include:				all areas mentioned in 2567, w		
					cleaned and sanitized.		
	During a kitchen tour with Cook 1, on 12/11/24 at						
	10:10 a.m., the following concerns were observed:						
					II. How other residents ha	ving	
	a. An open bag of	sugar in a bin containing			the potential to be affected by	-	
	unknown particles	of and trash in the bottom of			same deficient practice will be		
	the bin.				identified and what corrective		
	b. Clean cups, bowls, and plates stored upright,				action(s) will be taken; All		
	exposing the eating	surfaces.			residents receiving an oral die	t	
	c. A cart holding of	clean dishes visibly soiled with			have the potential to be affecte	ed.	
	dried food and spla	sh stains.					
	d. A bucket with d	lirty mop water and a mop					
	leaning against the	clean dishes rack.			III. What measures will be	put	
	e. A cleaning buck	xet with used cleaning cloths			into place and what systemic		
	stored under the ov	en.			changes will be made to ensu	re	
	f. Soiled serving	utensils on the preparation			that the deficient practice does	s not	
	table.				recur; All dietary staff were		
	g. Dried spillage a	and trash over the surface of the			educated on food storage,		
	floor.				labeling, cleaning and sanitation	on	
	h. An open sleeve	of bread on the preparation			by the consulting firm On-Tray	' .	
	table with no open	date on the packaging.			Cleaning schedules have beer	า	
	i. An open, uncov	vered box of cream of wheat			updated and assigned to each	l	
	with no open date of	on the packaging.			shift.		
	j. The three comp	artment sink with dried food at					
	the bottom and arou						
	k. A cart with used	d breakfast dishes standing			IV. How the corrective		
	next to the clean dis				action(s) will be monitored to		
	l. An open and undated bag of stuffing.				ensure the deficient practice w	/ill	
	m. One 32-ounce bottle of concentrated lemon				not recur i.e., what quality		
	juice, received on 3/19, with no open date in the				assurance program will be put	into	
	dry storage area.				place; Kitchen food storage a	reas	
		g of egg noodles received on			will be audited at least 5 times	а	
	10/15, with no oper	ı date.			week by the Dietary		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155799		(X2) MULTIPLE C A. BUILDING B. WING	OO OOSTRUCTION	(X3) DATE SURVEY COMPLETED 12/16/2024	
	PROVIDER OR SUPPLIER		614 W	ADDRESS, CITY, STATE, ZIP COD EST 14TH STREET DN, IN 46953	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N (X5) BE COMPLETION DATE
	date. p. A package of turas received on 12/1 in foil. q. One tub of chop r. The large floor of debris, and bits of f. s. The walls, sides tables were soiled v. The trash contain preparation table w. The ceiling vent with visible dark bl. vent. During a tour of the following was observed.	of equipment and preparation with dried spillage. her placed near the food ith no lid. over the food preparation table ack/brown matter hanging from the main dining room the rved: th visible dried spillage.		Manager/designee x 4 wee then 3 times a week by 4 w and then weekly until 100% compliance is achieved for consecutive months for dat labeling food items. The Dietary Manager/desig collect daily cleaning check sheets/cleaning schedules, assure that the cleaning an sanitizing is done and compafter each shift, by auditing areas at least 5 times a week weeks, then 3 times a week weeks and then weekly unt compliance is achieved for consecutive months.	eeks 3 ing and nee will off to d blete the ek x 4 x x 4 il 100% 30
	substance. d. Walls stained we substance. e. Warming table we and unknown debrif. Warming table of the warming table of the warming table of the night before. The been turned off after the cleaned after each of the cleaned after each of the clean whenever the substance.	with dried dark brown with dried substance on lids in water. eft on and hot to touch. ok 1 indicated the warming used since the evening meal the warming tables should have		The results of these audits reviewed in Quality Assural Meeting monthly x6 months until an average of 90% compliance or greater is ac x3 consecutive months. The Committee will identify any or patterns and make recommendations to revise plan of correction as indicated	hieved te QA trends

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155799		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	COM	TE SURVEY TPLETED 16/2024	
	PROVIDER OR SUPPLIEI N CARE MARION L		614 W	ADDRESS, CITY, STATE, ZIP CO EST 14TH STREET DN, IN 46953	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION d been cleaned.	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	RECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE
	Dietary Aide 2 indicart if she was work off on what needed washed the dishes was no deep cleaning one, but the last mareplaced it. During an interview Cook 3 indicated, a	v on 12/12/24 at 12:15 p.m., cated she tried to wash out the king. They just tried to trade to be done. Whomever would mop the floor. There ag schedule. There used to be mager took it down and never v on 12/13/24 at 10:14 a.m., fter each meal, the kitchenette ere wiped down and the floors				
	Corporate Regional the kitchen staff ne handling and clean was currently looki	v on 12/13/24 at 1:00 p.m., the Dietary Consultant indicated eded more education on fooding the kitchen. The facility ng for a new food service not know the last time the eaned.				
	Leftover Food" was 12/12/24 at 1:33 p.s following: "Guide properly handled, c food safety minima stored in the refrige labeled with a use be hours from the time	ated 2020, titled "Handling s provided by Administrator on m The policy indicated the eline: Leftover food will be ooled, and stored to ensure I waste 4. Leftover foods erator shall be wrapped, dated, by date that is no more than 72 to of first use. 5. Refrigerator rond 72 hours shall be				
	Rotation" was prov	ated 2020, titled "Cleaning ided by Administrator on m The policy indicated the				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155799	B. WING			12/16/2024	
NAME OF PROVIDER OR SUPPLIER APERION CARE MARION LLC			STREET ADDRESS, CITY, STATE, ZIP COD 614 WEST 14TH STREET MARION, IN 46953				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE			T	ID			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG				DATE
	"Guidelines: Equipment and utensils will be						
	cleaned and sanitized according to the following						
	guidelines, or manufacture's instructions.						
	Procedure: 1. Items cleaned and sanitized after						
	each use:Work tables and counters 2. Items						
	cleaned daily: stove topKitchen and dining room						
	floorsMop and mop buckets, Steam table, Hand						
	washing sink, Food carts, Pot and pan sink3.						
	Items cleaned weekly: filters, Coffee						
	machine4. Items cleaned monthly:Ingredient						
	bins Walls"						
	(Dry, Refrigerated, Administrator on 12 the following: " I guidelines to be fol labeled. The label food and the date be consumed, or discar	ated 2020, titled "Food Storage and Frozen)," provided by 2/12/24 at 1:33 p.m., indicated Procedure: 1. General storage lowed: a. All food items will be must include the name of the y which it should be sold, rded"					

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