PRINTED: 12/07/2021 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE SURVEY | |
|--|--|--------------------------------------|----------------|------------------------------------|------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING 00 | | COMPLETED | |
| 155766 | | B. WING | | 11/15/2021 | |
| | | | CTDE | EET ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF P | PROVIDER OR SUPPLIE | R | | W UTICA ST | |
| MADIEN | MANOR CHRISTIA | N HOME INC | | LERSBURG, IN 47172 | |
| | | IN FIGURE INC | J SEE | .LENGBONG, IN 47 172 | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | NCY MUST BE PRECEDED BY FULL | PREFIX | CROSS-REFERENCED TO THE APPROPRIA | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE |
| F 0000 | | | | | |
| | | | | | |
| Bldg. 00 | and the c | D | | | |
| | | Recertification and State | F 0000 | | |
| | Licensure Survey. | | | | |
| | C 1. N | 1 0 0 10 12 115 | | | |
| | • | ember 8, 9, 10, 12, and 15, | | | |
| | 2021 | | | | |
| | Facility mysskas: 0 | 000562 | | | |
| | Facility number: 0 Provider number: | | | | |
| | AIM number: 100 | | | | |
| | Anvi number. 100 | 207010 | | | |
| | Census bed type: | | | | |
| | SNF/NF: 43 | | | | |
| | Total: 43 | | | | |
| | 10 | | | | |
| | Census payor type: | : | | | |
| | Medicare: 1 | | | | |
| | Medicaid: 33 | | | | |
| | Other: 9 | | | | |
| | Total: 43 | | | | |
| | | | | | |
| | This deficiency reflects State findings cited in | | | | |
| | accordance with 41 | 10 IAC 16.2-3.1. | | | |
| | | | | | |
| | Quality review con | mpleted on November 21, | | | |
| | 2021. | | | | |
| F 0040 | 402.00/()/4//0) | | | | |
| F 0812 | 483.60(i)(1)(2) | | | | |
| SS=E | Food | /D /O O:t | | | |
| Bldg. 00 | | re/Prepare/Serve-Sanitary | | | |
| | • ,, | safety requirements. | | | |
| | The facility must | - | | | |
| | 8483 60(i)(1) - Dr | ocure food from sources | | | |
| | • (/(/ | sidered satisfactory by | | | |
| | federal, state or lo | | | | |
| | | de food items obtained | | | |
| | ., | I producers, subject to | | | |
| | | . p. 5446610, 645joot to | | | |
| LABORATOR | Y DIRECTOR'S OR PRO | OVIDER/SUPPLIER REPRESENTATIVE'S SIG | TITLE | (X6) DATE | |

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

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

000563

PRINTED: 12/07/2021 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | |
|--------------------------------|--|--------------------------------|--------|---|--|------------------|------------|--|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | A. BU | A. BUILDING 00 | | | COMPLETED | |
| 159 | | 155766 | B. W | B. WING | | | 11/15/2021 | |
| | | | | CTREET | ADDRESS, CITY, STATE, ZIP CODE | | | |
| NAME OF I | PROVIDER OR SUPPLIEI | ₹ | | | | | | |
| MAPLE MANOR CHRISTIAN HOME INC | | | | | UTICA ST | | | |
| MAPLE | VIANOR CHRISTIA | N HOME INC | | SELLE | RSBURG, IN 47172 | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION | |
| TAG | | | | TAG | DEFICIENCY | | DATE | |
| | applicable State a | and local laws or | | | | | | |
| | regulations. | | | | | | | |
| | (ii) This provision | does not prohibit or prevent | | | | | | |
| | facilities from usir | ng produce grown in facility | | | | | | |
| | gardens, subject t | to compliance with | | | | | | |
| | applicable safe gr | owing and food-handling | | | | | | |
| | practices. | | | | | | | |
| | · · · | does not preclude | | | | | | |
| | residents from co | nsuming foods not | | | | | | |
| | procured by the fa | acility. | | | | | | |
| | | | | | | | | |
| | §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | on and interview, the facility | F 0 | 312 | 1.) There were no residents | | 12/14/2021 | |
| | failed to ensure kitchen equipment, surfaces, and | | | | affected by the deficient practice | | | |
| | floors were free from food debris, rust, and | | | | | | | |
| | grease build-up of the walk-in freezer, metal | | | | 2.) There are no residents the | nat | | |
| | shelving, stove area, and deep fryer for 3 of 3 | | | | could have a potential to be affected by the deficient practice. | | | |
| | kitchen and dining observations. | | | | | | | |
| | F' 1' ' 1 1 | | | | 3.) The deep fryer, stove, floor | | | |
| | Findings include: | | | | | | | |
| | | | | | between deep fryer & stove, w | /all | | |
| | - | ion of the kitchen, on 11/8/21 | | | behind & right of stove and | | | |
| | | ollowing concerns were | | | electrical place are being | all | | |
| | observed: | | | thoroughly cleaned to remove a grease buildup & residual. | | dII | | |
| | 1. There was heavy white and yellow buildup of | | | | However, there are chemical | | | |
| | grease and food debris running down both sides | | | | | | | |
| | of the deep fryer and the stove and coating the | | | | stains/streaks that cannot be | 21/0 | | |
| | floor underneath and between them. There was a macaroni noodle lying in the grease between the | | | | removed from deep fryer & sto | | | |
| | | ing in the grease between the | | | with normal cleaning products | | | |
| | fryer and stove. | e, blackened area on the wall | | | steam cleaner is being purcha | | | |
| | | | | | to enhance cleaning abilities of | | | |
| | the oven vent. | hich appeared to be soot from | | | equipment in kitchen. The ste | alli | | |
| | | y and brown arouse seeting the | | | | | | |
| | | v and brown grease coating the | | | additional sanitizing process. | | | |
| | wall behind and to the right of the stove. Dark | | | | The blackened area which is | 2 | | |
| | brown grease could be observed coating the electrical plating on the wall beside the oven. | | | | The blackened area, which is | | | |
| | | | | | stain, on wall has been cleaned | | | |
| | 1 4. There was a near | yy reddish-brown buildup on | 1 | | and will be painted. Stainless | | I | |

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

Event ID:

SKC511 Facility ID: 000563

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PRINTED: 12/07/2021 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X | | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | |
|-----------------------------|---|--------------------------------|---------|--------------------------------------|---|------------------|------------|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | A. BU | JILDING | 00 | COMPLETED | |
| | | 155766 | B. WING | | | 11/15/2021 | |
| | | | | OTT DEF | ADDRESS CITY STATE TO SOFT | | |
| NAME OF F | PROVIDER OR SUPPLIER | 3 | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | UTICA ST | | |
| MAPLE N | MANOR CHRISTIAI | N HOME INC | | SELLE | RSBURG, IN 47172 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | | ID | DROWIDED'S DEAN OF CODDECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | .12 | DATE |
| | the underside of the | e metal shelf above the three | | | steel wall covering will be orde | ered | |
| | compartment sink. | | | | to go behind the stove, fryer, s | side | |
| | | | | | wall and warming oven. | - | |
| | During an observat | ion of the kitchen, on | | | | | |
| | 11/12/21 at 1:20 p.i | m., the following concerns | | | The metal shelf above the three-compartment since has | | |
| | were observed: | | | | | | |
| | 1. There was heavy | white and yellow buildup of | | | been removed, cleaned of bui | ldup | |
| | | oris running down both sides | | | and replaced. | | |
| | of the deep fryer an | nd the stove and coating the | | | | | |
| | floor underneath an | nd between them. There was a | | | The boxes in the walk-in freezer | | |
| | macaroni noodle ly | ing in the grease between the | | | have been moved. Staff have | | |
| | fryer and stove. | | | | been educated on need of have | ving | |
| | 2. There was a large | e, blackened area on the wall | | 18 inches of room between | | | |
| | behind the oven, which appeared to be soot from | | | product and ceiling. (see | | | |
| | the oven vent. | | | attached acknowledgement | | | |
| | 3. There was yellow | w and brown grease coating the | | | signature log) | | |
| | wall behind and to the right of the stove. Dark | | | | | | |
| | brown grease could be observed coating the | | | | The oven & vent above oven I | nave | |
| | electrical plating or | the wall beside the oven. | | | been cleaned with any dust | | |
| | 4. There was a heav | yy reddish-brown buildup on | | | accumulation removed. | | |
| | the underside of the | e metal shelf above the three | | | | | |
| | compartment sink. | | | 4.) The end of shift che | | | |
| | 5. There were sever | ral boxes of food items in the | | | have been updated to include a | | |
| | walk-in freezer stac | eked up to the ceiling. | | | 2nd staff member validating ta | asks | |
| | | | | | have been completed. (see | | |
| | During a follow-up visit to the kitchen, on | | | | attached). Staff will be update | ∌d | |
| | 11/15/21 at 9:35 a.m., the following concerns | | | | on updated checklist (see | | |
| | were observed: | | | | attached acknowledgement | | |
| | 1. The fryer had been cleaned; however some | | | | signature log). Dietary Manager | | |
| | white and yellow buildup did remain on the | | | | or designee will use the attached | | |
| | stainless steel sides. | | | QA form to review cleaning | | | |
| | 2. There was dust accumulated on the back of the | | | | schedules for completeness a | | |
| | oven, which was hanging down underneath the | | | | well as verifying cleanliness of | | |
| | vent. | | | deep fryer, stove, electrical plate, | | | |
| | | large area of the wall stained | | | wall behind stove, deep fryer a | | |
| | with black soot. | | | | warming oven, floor between deep | | |
| | | the walk-in freezer, including | | | fryer & stove, shelf above | | |
| | frozen chicken breasts, were touching the ceiling of the walk in freezer. | | | | three-compartment sink, vent/ | | |
| | | | | | and walk in freezer product to | | |
| | | ı | | ceiling height | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/07/2021 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | | |
|--|---|----------------------------------|----------------------------|---|---|------------------|------------|--|--|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BU | A. BUILDING <u>00</u> | | | COMPLETED | | | |
| 155766 | | B. W | B. WING 11/15 | | | 2021 | | | |
| | | | | STREET | ADDRESS, CITY, STATE, ZIP CODE | | | | |
| NAME OF PROVIDER OR SUPPLIER | | | | | | | | | |
| MAPLE MANOR CHRISTIAN HOME INC | | | | 643 W UTICA ST | | | | | |
| MAPLE | MANOR CHRISTIAL | N HOWE INC | | SELLEI | RSBURG, IN 47172 | | | | |
| (X4) ID | SUMMARY S' | TATEMENT OF DEFICIENCIES | | 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 APPROPRIAT | ΓF | COMPLETION | | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE | | |
| | During an interview | y, on 11/12/21 at 1:30 p.m., | | | | | | | |
| | the DM (Dietary Ma | anager) indicated they had | | | 5.) This QA will be completed | | | | |
| | daily cleaning lists, | but at the time they did not | | weekly for 2 months, then 1x weekly x 2 months then 1x ev weeks until review at 2nd qtr 0 | | | | | |
| | have enough people | to do it all. The buildup | | | | | | | |
| | under the shelf above | ve the sink was rust she | | | | | | | |
| | believed. She would | d clean it, and it would build | | | meeting for 2022. QA's will be reviewed at QA meeting to | | | | |
| | back up due to the r | noisture. The area of soot had | | | | | | | |
| | been there a while, | they were going to eventually | | | determine if QA can stop or wi | II | | | |
| | paint over it. It was | due to an issue with the stove | | | need to be continued and at w | hat | | | |
| | that was now fixed. | The grease staining the wall | | | frequency if so. | | | | |
| | had not been cleaned in a while. The deep fryer | | | | | | | | |
| | had been cleaned a couple of weeks ago, but the | | | | | | | | |
| | sides and floor had clearly not been cleaned and clearly needed to be done. | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | During an interview | y, on 11/15/21 at 9:05 a.m., | | | | | | | |
| | the DM indicated th | ey had cleaned the deep fryer | | | | | | | |
| | and stove, however | there was some residual | | | | | | | |
| | grease, and they wo | uld have to continue to work | | | | | | | |
| | at it. They had tried | to clean the burnt area of the | | | | | | | |
| | wall. It was from w | here the oven had been pushed | | | | | | | |
| | too far against the w | vall. They had pulled it out and | | | | | | | |
| | tried to clean it, but | it was taking the paint off the | | | | | | | |
| | I - | the shelf above the sink and | | | | | | | |
| | | en rusted. They had daily and | | | | | | | |
| | weekly cleaning tasks to do, but some things had | | | | | | | | |
| | | 5 a.m., the DM indicated | | | | | | | |
| | boxes in the freezer should not be touching the | | | | | | | | |
| | ceiling. Stuff should not be touching the ceiling, | | | | | | | | |
| | normally don't have this much in there, we | | | | | | | | |
| | 1 | have the cart in there, but | | | | | | | |
| | | etting food and stocked up on | | | | | | | |
| | | olidays. At 10:54 a.m., the | | | | | | | |
| | | ould not find a policy or a | | | | | | | |
| | _ | how far boxes should be | | | | | | | |
| | _ | he walk in freezer, but they | | | | | | | |
| | | n touching the ceiling, as it | | | | | | | |
| | provided inadequate | e circulation. | | | | | | | |
| | | | | | | | | | |
| | The most current en | d of shift reminder checklist, | | | | | | | |

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Event ID:

SKC511

Facility ID: 000563

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/07/2021 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | | | |
|---------------------------|--|--------------------------------|--------------|---------------------------------|--|------------------|------------|--|--|--|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | A. BUILDING | A. BUILDING 00 | | COMPLETED | | | | |
| | | 155766 | B. WING | 00 | | 11/15/2021 | | | | |
| | | 1 .33.30 | CALL CALL | ET ADDRE | COO CUTTY OF THE THE CODE | , | | | | |
| NAME OF P | ROVIDER OR SUPPLIE | R | | | ESS, CITY, STATE, ZIP CODE | | | | | |
| NAADI E N | AANOD OUDIOTIA | NI LIONAE INIO | | W UTIC | | | | | | |
| MAPLE | MANOR CHRISTIA | N HOME INC | SEL | SELLERSBURG, IN 47172 | | | | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | | | PROVIDER'S PLAN OF CORRECTION | | | | | |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | PREFIX | REFIX (EACH CORRECTIVE ACTION S | | OULD BE | COMPLETION | | | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION) | TAG | - Ort | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | DATE | | | |
| | provided on 11/15/ | 21 at 9:05 a.m., indicated the | | | | | | | | |
| | PM Cook was to cl | | | | | | | | | |
| | daily. | | | | | | | | | |
| | | | | | | | | | | |
| | The most current w | | | | | | | | | |
| | on 11/15/21 at 9:05 a.m., indicated staff were to | | | | | | | | | |
| | clean the ovens, and clean and polish all stainless steel. | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | The most current Cleaning Policies and Procedures, provided on 11/15/21 at 10:54 a.m., | | | | | | | | | |
| | | | | | | | | | | |
| | included, but was not limited to, "Cleaning | | | | | | | | | |
| | · | e, food is a very important | | | | | | | | |
| | | nandling. All surfaces must be | | | | | | | | |
| | • | e basis as well as whenever | | | | | | | | |
| | | s will be kept clean and free | | | | | | | | |
| of spills and grease" | | | | | | | | | | |
| | 1 8 | | | | | | | | | |
| | 3.1-21(i)(3) | | | | | | | | | |
| | - ()(0) | | | | | | | | | |

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Event ID:

SKC511

Facility ID: 000563

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