

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155482	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/18/2013
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NAME OF PROVIDER OR SUPPLIER KENDALLVILLE MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1802 E DOWLING ST KENDALLVILLE, IN 46755
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 02/18/13</p> <p>Facility Number: 000529 Provider Number: 155482 AIM Number: 100267140</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Kendallville Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. Battery operated smoke detectors have been installed in the resident rooms. The</p>	K0000	<p>This plan of correction is to serve as Kendallville Manor's credible allegation of compliance.</p> <p>Submission of this plan of correction does not constitute an admission by Kendallville Manor or their management companies that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement of the survey allegations.</p>	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>facility has a capacity of 60 and had a census of 34 at the time of this survey.</p> <p>All areas where the residents have customary access are sprinklered. The facility does have a barn and a shed providing facility services that were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/21/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K0029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 doors entering the kitchen, a hazardous area, would self close and latch into the door frame. This deficient practice could affect residents in the main dining room with a seating capacity of at least 21 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 02/18/13 at 1:13 p.m., the north kitchen door between the kitchen and the main dining room failed to latch into the frame. Based on an interview with the Maintenance Director at the time of observation, the hinges need adjusting.</p> <p>3.1-19(b)</p>	K0029	<p>K029 NFPA 101 Life Safety Code Standard The latch on the north kitchen door between the kitchen and main dining room was adjusted on 2-18-13. The attached form is used by Maintenance. This item is to be checked monthly and issues or necessary changes it will be reported at the QA Committee Meeting. (Attachment # 1)</p>	03/31/2013	

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K0038 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 5 of 5 exit doors were accessible. Health care occupancies permit delayed-egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(d) requires on the door adjacent to the release device there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in width on a contrasting background that reads as follows: "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 02/18/13 from 12:38 p.m. to 1:19 p.m., the exit doors on the 100 hall, 200 hall, on the south hall and at the main entrance were equipped with electromagnetic locks which released after fifteen seconds but lacked the proper signage. Additionally, the main dining room exit door, which was equipped with a electromagnetic lock, did not release after fifteen seconds. At this time the Maintenance Director could not</p>	K0038	<p>K038 NFPA 101 Life Safety Code Standard Signage has been placed on all exit doors informing that the doors will released after 15 seconds. (Attachment # 2) The main dining room exit door didn't release after 15 seconds. Safe Care adjusted the main dining room exit door and egress is set to release at 15 seconds. (Attachment # 3) The Door Alarm Systems per facility policy are to monitor the doors every week. (Attachment #4 and # 5) Any issues or necessary changes will be reported at the QA Committee Meeting.</p>	03/31/2013			

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	confirm whether the door should release after fifteen seconds as all the remaining doors in the facility do, or if this door was wired not to release. 3.1-15(b)			

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K0046 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation, record review and interview; the facility failed to ensure 1 of 2 emergency light fixtures of at least 1½ hour duration was tested monthly and annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. In addition, NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 02/18/13 at 1:15</p>			K0046	<p>K046 NFPA 101 Life Safety Code Standard</p> <p>The Outside Emergency Lights operating during generator test for 2012 was located. (Attachment # 6)</p> <p>2013 generator test are attached to show that the testing is being conducted (Attachment # 7)</p> <p>This testing is done on a monthly basis and if there are any issues or necessary changes it will be reported at the QA Committee Meeting.</p>		03/31/2013

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	<p>p.m., there was a battery operated emergency task light at the emergency generator. Based on record review with the Maintenance Director at 11:40 a.m., documentation was not available regarding the battery operated emergency task light at the generator. Based on an interview with the Maintenance Director at the time of record review, he was unable to locate the documentation.</p> <p>3.1-19(b)</p>				

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K0048 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a written plan which included the different types and the use of fire extinguishers provided in the facility in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on a record review with the Maintenance Director on 02/18/13 at 11:52 a.m., the "Disaster Plan" at the nurses' station did not address the types of fire extinguishers throughout the facility including the kitchen K-class fire extinguisher in relationship with the use</p>			K0048	K048 NFPA Life Safety Code Standard Reeducation was provided to the kitchen staff on the Use of ABC Extinguishers and K Class extinguisher use. (Attachment # 8)		03/31/2013

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	<p>of the kitchen hood extinguishing system. The "Disaster Plan" in the maintenance office did address the type of fire extinguishers with the exception of the kitchen K-class. This was acknowledged during the exit conference on 02/18/13 at 1:45 p.m. by the Maintenance Director and the Administrator who then updated the form with plans to update the "Disaster Plan" at every location in the facility.</p> <p>3.1-19(b)</p>				

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K0050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the "Fire & Evacuation Drill Report" with the Maintenance Director on 02/18/13 at 11:10 a.m., there was no record of a third shift fire drill for the third quarter of 2012. Based on an interview with the Maintenance Director after he reviewed his fire drill documentation, he did not do a third shift fire drill for the third quarter of 2012.</p> <p>3.1-19(b) 3.1-51(c)</p>	K0050	<p>K050 NFPA Life Safety Code Standard</p> <p>Monthly fire drills have been scheduled for 2013 (Attachment # 9).</p> <p>The monthly fire drills will be reviewed monthly by Administrator or Designee. Results will be brought to the QA Committee Meeting.</p>	03/31/2013			

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K0066 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 self closing metal trash cans in the smoking area was used to empty ashtrays only. This deficient practice could affect at least 5 residents who currently smoke and residents evacuated through the south exit in the event of an emergency.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 02/18/13 at 12:50 p.m., the metal trash can in the</p>	K0066	<p>K066 NFPA Life Safety Code Standard</p> <p>A laminated sign has been placed on the self closing metal trash can for "Cigarette Butts Only" (Attachment # 10)</p> <p>The metal trash cans will be checked by housekeeping 2 times per day. (Attachment # 11</p>	03/31/2013

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	<p>resident smoking area contained a mixture of cigarettes butts and combustible trash. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p>				

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K0144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to provide the complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. NFPA 99, Section 3-4.1.1.8 states the generator set shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. This deficient practice affects all occupant.</p> <p>Findings include:</p> <p>Based on review of the generator log titled "Monthly Test Log" with the Maintenance Director on 02/18/13 at 11:30 a.m., the emergency generator was tested monthly under load for at least 30 minutes, however, the monthly load test record did not include the time for the transfer of power from the main source to the generator. This was acknowledged by the Maintenance Director.</p> <p>3.1-19(b)</p>	K0144	<p>K144 NFPA Life Safety Code Standard</p> <p>The Emergency Generator – Monthly Test Log will include the time of transfer. If there are any issues or necessary changes, this will be brought to the QA Committee Meeting. (Attachment # 12)</p>	03/31/2013	

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