

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155482	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/25/2011
NAME OF PROVIDER OR SUPPLIER  KENDALLVILLE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1802 E DOWLING ST KENDALLVILLE, IN46755		
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F0000	<p>This visit was for the Investigation of Complaint IN00094654. This visit resulted in a partially extended survey-immediate jeopardy.</p> <p>Complaint IN00094654 - Substantiated. Federal/state deficiencies related to the allegations are cited at F323 and F9999.</p> <p>Survey date: August 23, 2011 Extended survey dates: August 24, 25, 2011</p> <p>Facility number: 000529 Provider number: 155482 AIM number: 100267140</p> <p>Survey team: Ann Armey, RN Carol Miller, RN, August 24, 25, 2011</p> <p>Census bed type: SNF/NF: 24 Total: 24</p> <p>Census payor type: Medicare: 4 Medicaid: 18 Other: 2 Total: 24</p> <p>Sample: 3</p>	F0000	<p><b>This plan of correction is to serve as Kendallville Manor's credible allegation of compliance.</b></p> <p><b>Submission of this plan of correction does not constitute an admission by Kendallville Manor or it's management company 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 or admission of the survey allegations.</b></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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F0323 SS=J	<p>Supplemental Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 8/29/11 by Suzanne Williams, RN The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on interviews and record review, the facility failed to ensure the safety of a resident, who left the facility unattended and failed to develop a plan to prevent the incident from reoccurring.</p> <p>This resulted in the potential for serious harm for 1 of 1 resident, who left the facility unattended, in a sample of 3. (Resident #B)</p> <p>The immediate jeopardy began on 7/25/11, when a resident left the facility unattended. The Administrator, Administrator in Training, Social Services Director and the Assistant Director of Nursing were notified of the immediate jeopardy on 8/23/11 at 2:15 p.m.</p> <p>The immediate jeopardy was removed on 8/24/11 but the non-compliance remained at a lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p>			F0323	<p><b>F323 483.25(h) ACCIDENTS</b></p> <p>It is the practice of Kendallville Manor to ensure that the resident's environment remains as free from accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>I. Resident B has been assessed and showed no signs/symptoms of injury. The elopement risk assessment and care plan has been reviewed and updated.</p> <p>II. All residents have been reassessed for elopement risk potential; those who are identified to be at risk have an appropriate care plan in place and updated on 8/23/2011. Residents determined to be at risk for elopement have an identification picture and relocation information in the Elopement Risk Book which is maintained at the nurses station. Facility personnel have been re-educated on this book and</p>		09/02/2011

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	<p>Findings include:</p> <p>On 8/23/11 at 10:10 a.m., during interview, CNA #1 indicated she came to work one morning toward the end of July 2011 and LPN #2 told her, during the night, Resident #B went to a store in his scooter and was escorted back to the facility by the police. CNA#1 indicated the ADON (Assistant Director of Nursing) was notified and came to the facility.</p> <p>The clinical record of Resident #B was reviewed on 8/23/11 at 10:30 a.m., and indicated the resident was admitted to the facility on 4/18/08, with diagnoses which included, but were not limited to, schizophrenia, depression, schizo-affective disorder and history of encephalopathy.</p> <p>The Quarterly MDS (Minimum Data Set) Assessment, dated 7/15/11, indicated Resident #B received a score of 15 on the Brief Interview of Mental Status indicating he had no cognitive impairments. The MDS indicated the resident required extensive assistance for transfer, dressing, bathing and toileting, and had no behaviors coded.</p> <p>Elopement risk assessments dated 3/25/11 and 8/10/11, respectively, indicated</p>		<p>relocation policy.</p> <p>III. The facility's policy regarding door alarms has been reviewed and revised to ensure all exit doors are continuously alarmed when exiting the facility. Facility personnel have been educated on this policy. Additional alarms have been installed on exit doors at the end of each corridor to ensure an audible sound is emitted upon opening the door. Licensed nurses have been re-educated regarding the need to document resident incidents in the clinical record. All incidents are reviewed during morning clinical meeting to ensure appropriate plan of care is in place and revised as necessary and that notification to appropriate agencies has occurred.</p> <p>IV. The Administrator or her designee is conducting quality improvement audits of the exit door alarm system. Exit door alarm function is being checked at random times daily for 2 weeks and weekly thereafter. In addition, Licensed Nurses are validating exit door alarm engagement every four hours for two weeks and then one time per shift thereafter. Results of all audits will be reviewed by the facility's Quality Assurance Committee weekly for four weeks and then monthly.</p>		

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	<p>Resident #B was not at risk for elopement.</p> <p>The 8/10/11, elopement assessment indicated the resident had no history of elopement.</p> <p>The August 2011, MAR (Medication Administration Record) indicated the resident received, among other medications, the following psychoactive medications: Haloperidol Decanoate 200 mg, intramuscularly, every 21 days; Risperidone 1.5 mg, three times daily; Depakote 250 mg, three times daily and Ativan 0.25 mg, every eight hours</p> <p>The resident requested additional PRN (as needed) Ativan for anxiety/panic attacks 10 times in August 2011.</p> <p>There was no documentation in the clinical record regarding the elopement incident, and there was no care plan related to elopement.</p> <p>On 8/23/11 at 11:00 a.m., the Administrator indicated, around 3:00 a.m. on 7/25/11, staff got Resident #B up and he went out to smoke. The Administrator indicated, about 20 to 30 minutes later, the nurse received a call from the police saying Resident #B was at a store which was about 0.5 miles from the facility. The Administrator indicated the night shift staff were not aware the resident was</p>				

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	<p>missing until the police called. The Administrator further indicated, the incident was not reported to the ISDH (Indiana State Department of Health), because the resident was not cognitively impaired and the facility did not have to call the police because the police called the facility.</p> <p>On 8/23/11 at 11:15 a.m., the ADON (Assistant Director of Nursing) indicated she was called by LPN #2 on 7/25/11 at 3:30 a.m. and she came into the facility. Resident #B was assessed and had no injuries. The ADON indicated there was no documentation of the incident in the clinical record, no incident report and no investigation because the resident was not cognitively impaired and was free to come and go.</p> <p>On 8/23/11 at 12:40 p.m., LPN #2 indicated she had worked the night shift on 7/25/11. LPN #2 indicated she got Resident #B up around 2:30 a.m. and he went out back in the fenced patio area for a smoke while she and the aide were doing rounds. She indicated she was not aware he had left the facility grounds until the police called and felt he must have left through the front door. LPN #2 indicated the alarm on the front door was not turned on, and she was not aware the alarm on the front door should be turned on until</p>				

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	<p>after the incident.</p> <p>On 8/23/11 at 3:00 p.m., during interview, Resident #B indicated the nurse woke him up to ask if he wanted a suppository, and he could not get back to sleep so he got up to have a smoke. The resident indicated, after he finished smoking, he came back into the facility, no staff were present so he went out the front door. Resident #B indicated, when he left, the front door was unlocked and did not alarm. Resident #B indicated he went down Dowling Road and turned on a side street. His plan was to go to the store and back, but the police stopped him and called the facility. The resident indicated the police followed him back to the facility while he drove his motorized wheelchair.</p> <p>The police report indicated LPN #2 "advises he is not supposed to be off the property and (Resident #B's Name) was returned safely on 7/25/11 at 3:40 a.m."</p> <p>Interview with a night nurse, RN #3, on 8/24/11 at 7:40 a.m., indicated she had been employed at the facility for approximately three weeks. RN #3 indicated she had been trained to lock the front doors to keep people out, but had not been trained to turn on the alarm at the front door, until last night, 8/23/11.</p>						

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	<p>Interview with the Administrator-in-training, who was the former Director of Nursing at the facility, on 8/24/11 at 8:15 a.m., indicated there was no policy to turn on the alarm to the front door. In practice, they were locking the front door but not turning on the alarm. They lock the doors at 10:00 p.m., and this kept people from coming in but did not prevent people from going out, since the door would open when the bar was pushed from the inside.</p> <p>The Administrator provided a list of five residents at risk of elopement on 8/23/11. Resident #B was not on this list. On 8/24/11 at 8:30 a.m., the Administrator indicated all residents had been assessed for elopement risk, and there are now seven residents identified as at risk of elopement in the facility, and this included Resident #B.</p> <p>The immediate jeopardy that began on 7/25/11 was removed on 8/24/11, when the facility assured alarms were turned on, were present on the exit doors, and inserviced staff, but the noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy because of the need for ongoing monitoring.</p>				

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F9999	<p>This Federal tag relates to Complaint IN00094654.</p> <p>3.1-45(a)(2)</p> <p>State Finding:</p> <p>3.1-13 Administration and Management</p> <p>(g) The administrator is responsible for the overall management of the facility but shall not function as a department supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interviews and record review, the facility failed to report an incident of elopement to the Indiana State Department of Health.</p> <p>This deficiency affected 1 of 1 resident,</p>	F9999	<p><b>F999 STATE FINDING</b> It is the practice of Kendallville Manor to immediately inform the division by telephone followed by written notice within 24 hours of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents. I. Resident B has been assessed and showed no signs/symptoms of injury. The elopement risk assessment and care plan has been reviewed and updated. II. All residents have been reassessed for elopement risk potential; those who are identified to be at risk have an appropriate care plan in place and updated on 8/23/2011. Residents determined to be at risk for elopement have an identification picture and relocation information in the Elopement Risk Book which is maintained at the nurses station. Facility personnel have been re-educated on this book and relocation policy. III. The facility's policy regarding door alarms has been reviewed and revised to ensure all exit doors are continuously alarmed when exiting the facility. Facility personnel have been educated on this policy. Additional alarms</p>	09/02/2011	

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	<p>who left the facility unattended, in a sample of 3. (Resident #B)</p> <p>Findings include:</p> <p>On 8/23/11 at 10:10 a.m., during interview, CNA #1 indicated she came to work one morning toward the end of July 2011 and LPN #2 told her, during the night, Resident #B went to a store in his scooter and was escorted back to the facility by the police.</p> <p>The clinical record of Resident #B was reviewed on 8/23/11 at 10:30 a.m., and indicated the resident was admitted to the facility on 4/18/08, with diagnoses which included, but were not limited to, schizophrenia, depression, schizo-affective disorder and history of encephalopathy.</p> <p>The Quarterly MDS (Minimum Data Set) Assessment, dated 7/15/11, indicated Resident #B received a score of 15 on the Brief Interview of Mental Status indicating he had no cognitive impairments. The MDS indicated the resident required extensive assistance for transfer, dressing, bathing and toileting, and had no behaviors coded.</p> <p>Elopement risk assessments dated 3/25/11</p>		<p>have been installed on exit doors at the end of each corridor to ensure an audible sound is emitted upon opening the door. Licensed nurses have been re-educated regarding the need to document resident incidents in the clinical record. All incidents are reviewed during morning clinical meeting to ensure appropriate plan of care is in place and revised as necessary and that notification to appropriate agencies has occurred. The Administrator attends the morning meeting and will report to ISDH immediately as required. IV. The Administrator or her designee is conducting quality improvement audits of the exit door alarm system. Exit door alarm function is being checked at random times daily for 2 weeks and weekly thereafter. In addition, Licensed Nurses are validating exit door alarm engagement every four hours for two weeks and then one time per shift thereafter. All incidents of unusual occurrence are reviewed during morning meeting and will be reviewed during monthly QA to assist in monitoring for reporting to appropriate agencies. Results of all audits will be reviewed by the facility's Quality Assurance Committee weekly for four weeks and then monthly.</p>		

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	<p>and 8/10/11, respectively, indicated Resident #B was not at risk for elopement. The 8/10/11, elopement assessment indicated the resident had no history of elopement.</p> <p>There was no documentation in the clinical record regarding the elopement incident, and there was no care plan related to elopement.</p> <p>On 8/23/11 at 11:00 a.m., the Administrator indicated, around 3:00 a.m. on 7/25/11, staff got Resident #B up and he went out to smoke. The Administrator indicated, about 20 to 30 minutes later, the nurse received a call from the police saying Resident #B was at a store which was about 0.5 miles from the facility. The Administrator indicated the night shift staff were not aware the resident was missing until the police called. The Administrator further indicated, the incident was not reported to the ISDH (Indiana State Department of Health), because the resident was not cognitively impaired and the facility did not have to call the police because the police called the facility.</p> <p>On 8/23/11 at 12:40 p.m., LPN #2 indicated she had worked the night shift on 7/25/11. LPN #2 indicated she got</p>				

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	<p>Resident #B up around 2:30 a.m. and he went out back in the fenced patio area for a smoke while she and the aide were doing rounds. She indicated she was not aware he had left the facility grounds until the police called and felt he must have left through the front door. LPN #2 indicated the alarm on the front door was not turned on, and she was not aware the alarm on the front door should be turned on until after the incident.</p> <p>On 8/23/11 at 3:00 p.m., during interview, Resident #B indicated the nurse woke him up to ask if he wanted a suppository, and he could not get back to sleep so he got up to have a smoke. The resident indicated, after he finished smoking, he came back into the facility, no staff were present so he went out the front door. Resident #B indicated, when he left, the front door was unlocked and did not alarm. Resident #B indicated he went down Dowling Road and turned on a side street. His plan was to go to the store and back, but the police stopped him and called the facility. The resident indicated the police followed him back to the facility while he drove his motorized wheelchair.</p> <p>The police report indicated LPN #2 "advises he is not supposed to be off the property and (Resident #B's Name) was returned safely on 7/25/11 at 3:40 a.m."</p>						

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