

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  12/23/2014
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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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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: December 17, 18, 19, 22, &amp; 23, 2014</p> <p>Facility number: 000529 Provider number: 155482 AIM number: 100267140</p> <p>Survey team: Rick Blain, RN - TC Tim Long, RN Carol Miller, RN Diane Nilson, RN</p> <p>Census bed type: SNF/NF: 32 Total: 32</p> <p>Census payor type: Medicare: 5 Medicaid: 21 Other: 6 Total: 32</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on December 24, 2014 by Randy Fry RN.</p>	F000000	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. In lieu of a revisit, we respectfully request a Desk Review.	

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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F000322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a gastrostomy tube was checked for placement and residual prior to medication administration through the gastrostomy tube. This deficiency had the potential to affect 1 of 1 resident who received medication administration through a gastrostomy tube (Resident #1).</p> <p>Findings include:</p>	F000322	The facility does ensure that the residents receiving adequate care and services administering G Tube feedings.F322 483.25 (g)(2) NG Treatment/Services Restore Eating SkillsIn-service have been completed (Attachment #1) with Nurses/QMA's on "Enteral Tube Medication Administration Policy and Procedure." (Attachment #2)Potential affect to all residents with Enteral Tube Medication Administration.The resident's MAR will reflect safe delivery practices by checking placement	01/09/2015			

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	<p>On 12/19/14 at 12:00 P.M. QMA (Qualified Medication Aide) #4 was observed during medication administration of Resident #1 medications. QMA # 4 was observed to check the resident's Medication Administration Record and then QMA #4 removed Tums 500 milligrams 2 tablets and crushed the Tums. QMA #4 was observed to flush the gastrostomy tube (g-tube tube) with 30 cc's (cubic centimeters) of water with an Asepto syringe. QMA #4 was not observed to check the placement or residual of Resident #1's g-tube prior to flushing the g- tube with the water. QMA #4 was then observed to mix the crushed Tums medication with 30 cc of water and administer the Tums through the Asepto syringe into the g- tube.</p> <p>The Physician's Order dated 3/28/06 indicated to check the g- tube for residual prior to the administration of medications through the resident's g- tube.</p> <p>On 12/19/14 at 12:10 P.M. QMA #4 was interviewed and indicated he did not check for placement or residual of Resident #1's g-tube prior to the administration of the Tums medication though the g-tube. QMA #4 further indicated he had checked the placement</p>		and residual as well medication administration. The facility has 1 resident who receives enteral medication. The DON or designee will perform audits of medication administration via G-Tube (Attachment #3), checking for placement and residual. Audit will be performed each week x 4 weeks, then monthly thereafter to ensure safe delivery of medication via G-Tube. Results of the audits are being reported x 1 month in the facility QA Committee Meeting for additional recommendation as necessary.	

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F000465 SS=D	<p>of the g-tube that morning before he had administered Resident #1's 6:00 A.M. medications and since the resident was not on a continuous g-tube feeding and no one else had accessed the g-tube prior to the 12:00 P.M. medication administration of the Tums through the g-tube, he did not recheck the placement.</p> <p>12/19/14 at 12:15 P.M. an interview with Director of Nursing (DON) indicated QMA #4 should have used a stethoscope and air to check for the placement of the g-tube and prior to administering the Tums QMA #4 should have checked for residual of the resident's stomach contents .</p> <p>3.1-44(a)(2)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure 2 resident bath rooms were without environmental concerns. This deficiency had the potential to affect 2 of 29 resident rooms observed for environmental concerns (Room # 208 and #212).</p>	F000465	F465 Safe/Functional/Sanitary/Comfortable Environment Rooms 208 and 212. In-service completed with CNAs/Nurses/QMA's on how to record maintenance issues from residents' rooms in the Maintenance Book. (Attachment #4) Potential to affect all residents staying at Kendallville Manor. An	01/21/2015

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	<p>Findings include:</p> <p>1. During an observation of the bathroom in room #208 on 12/17/14 at 11:42 A.M., the floor tiles were dull and scuffed with black marks in front of the toilet and the caulking that adhered the sink cabinet to the wall was observed to be cracked. Also observed was a piece of paint that was chipped from the wall to the left of the sink cabinet.</p> <p>On 12/23/14 at 10:15 A.M. with the Maintenance Director and the Administrator in room #208 observed in the resident's bathroom the tiles in front of the toilet were dull and scuffed with black marks and the caulking that adheres the sink cabinet to the wall was cracked. Also observed was peeling paint on the wall behind the sink measured by the Maintenance Director 2 1/2 inches long.</p> <p>Interview with the Maintenance Director on 12/23/14 at 10:30 A.M. indicated there is a communication book located at the nurses station and the staff are supposed to document any areas that need repaired. The Maintenance Director indicated he was not aware the bathroom in room #208 had dull floor tiles in front of the toilet, and cracked caulking and peeling paint on the wall.</p>		Environmental Quality Improvement Audit (Attachment #5) will be conducted every week for four weeks then monthly and reviewed at the next 2 Quality Assurance meetings.		

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	<p>2. The bathroom in room #212 was observed on 12/18/14, at 1:35 P.M. The entire left side of the cabinet floor under the sink was caved in, and the cabinet floor had black/brown discolored stains. There was a hole in the back wall under the sink, on the same side as the cabinet floor where the plumbing could be seen. The Maintenance Director was interviewed, on 12/18/14, at 1:40 P.M., regarding the cabinet floor. He indicated he was not made aware of the area under the sink cabinet, and indicated the area was dry and old, and no one had informed him or he would have fixed the area. He indicated it appeared the dry wall on the back wall of the cabinet had been cut out due to a leak in the plumbing, but he was unaware of when this had been done.</p> <p>In addition, the baseboard on both sides of the corner wall to the left of the bathroom cabinet was loose and peeling away from the wall. The Maintenance Director was interviewed, on 12/23/14, at 10:35 A.M., and indicated the loose baseboard on the corner wall measured an area of 5 and 1/2 inches on the wall nearest the bathroom cabinet, and 4 inches on the wall under the grab bar to the left of the bathroom cabinet. He indicated this was caused by the resident's wheelchair.</p>						

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

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	3.1-19(f)				