

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 03/13/2014
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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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K010000	<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: 03/13/14</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, in areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a</p>	K010000	<p>This plan of correction is to serve as Kendallville Manor's credible allegation of compliance. 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 life safety and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</p>	
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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>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 03/18/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			
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K010025 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 03/13/14 from 1:20 p.m. to 2:28 p.m., there were unsealed ceiling penetrations in the following locations:</p> <p>a. four of four ceiling penetrations measuring from one eighth inch to one inch around one conduit, two gas lines and an electrical wire in the water heater room,</p> <p>b. behind the dryers around a gas line</p>	K010025	The ceiling penetrations have been caulked with fire proof caulk.All resident have the potential to be affected.Ceiling penetrations will be reviewed week during "Sprinkler Line Checklist/Ceiling Penetrations" (attachment # 1) The Maintenance Director or Designee will monitor weekly. Results will be reported to the QA Committee Meeting, overseen by the Administrator, monthly for additional recommendations as necessary	04/12/2014			

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	<p>measuring three fourths inch, c. three of thirteen ceiling penetrations measuring from one eight inch to one half inch around the sprinkler lines in the Nursing supply room. Measurements were provided by the Maintenance Director at the time of observations.</p> <p>3.1-19(b)</p>			
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K010029 SS=F	<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 the corridor door to 1 of 2 shower rooms used for storage of soiled linen therefore creating a hazardous area, and 1 of 1 combustible storage rooms were provided with a door that would self close and latch into the frame. This deficient practice could affect all 34 residents in the 100 and 200 halls.</p> <p>Findings include:</p> <p>a. Based on observation with the Maintenance Director on 03/13/14 at 1:50 p.m., the corridor door to the 100 hall shower room did self close but failed to latch into the door frame. The 100 hall shower room contained one barrel with soiled linen. The Maintenance Director acknowledged the barrel was stored in the 100 hall shower room at the time of</p>	K010029	Adjusted door closure to 100 hall shower and door latches. Purchased door hinges for Room 217. All residents have the potential to be affected. 100 Shower Room door Latches Installed spring loaded hinge to Room 217. Maintenance Director or Designee Conduct monthly audits using "Monthly Life Safety Checklist". (attachment # 2) Maintenance Director or Designee will conduct audits (attachment # 3) every week for 4 weeks, the monthly thereafter. Results of audit will be brought to QA Committee which is held monthly for additional recommendation if necessary.	04/12/2014			

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	<p>observation.</p> <p>b. Based on observation with the Maintenance Director on 03/13/14 at 1:10 p.m., resident room 217, measuring 176 square feet in size, was used for the storage of 25 cardboard boxes of old employee's files, two boxes of toilet paper and six boxes of paper towels. The corridor door lacked a self closing device. Measurements were provided by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p>			
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K010038 SS=E	<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 1 of 5 exit doors was 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(c) requires an irreversible process shall release the lock within 15 seconds upon application of a force to the release device. This deficient practice could affect any residents evacuated through the service hall from the main dining room in the event of an emergency. This deficient practice could affect 1 of 3 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 03/13/14 at 1:35 p.m., the exit door near the nurses' station was equipped with an electromagnetic lock. When the Maintenance Director applied force to the door for twenty seconds, there was no alarm and the door failed to release. A sign above the door indicated it would release in 15 seconds. The door did release upon activation of the fire alarm system. The Maintenance Director acknowledged the exit door did not release after 20 seconds.</p>	K010038	<p>Contacted Safe Care to evaluate the exit door and the alarming mechanism. All residents have the potential to be affected. Safe Care assessed door and alarm 3-28-14 and adjusted the sensitivity. (attachment # 4) Maintenance Director or Designee will Monitor Door Alarms weekly. (attachment # 5) Results of audit will be brought to QA meeting monthly for additional recommendations, if necessary.</p>	04/12/2014			

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K010062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure the spray pattern for the sprinkler head in 1 of 1 closets in resident room 217 was unobstructed. LSC 9.7.5 requires all automatic sprinkler systems be inspected, tested and maintained in accordance with NFPA 25, Standard for the inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. Since resident room 217 was used as storage this deficient practice could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 03/13/14 at 1:15 p.m., the spray pattern of the closet sprinkler head in the resident room 217 was obstructed by bedding piled on the closet shelf. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p>	K010062	Removed bedding obstructing sprinkler head in the closet All residents have the potential to be affected. Removed the bedding. Wall was marked 18 " down from ceiling. Maintenance Director or Designee will Monitor weekly using "18" Sprinkler Line Checklist/Ceiling Penetrations". (attachment # 1) Results of audit will be brought to QA meeting monthly for further recommendations if necessary	04/12/2014			

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K010144 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. Based on record review and interview, the facility failed to provide the complete documentation of a weekly visual inspection for 1 of 1 emergency generators providing power to the emergency systems. NFPA 99, 3-5.4.2 requires a written record or inspection, performance, exercise period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 99, 3-4.1.1(b)1 requires generating testing be in accordance with NFPA 110, Standard for Emergency and Standby power Systems, Chapter 6. NFPA 110, 6-4.1 requires Level 1 and Level 2 EPSS including all appurtenant components shall be inspected weekly. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on a review of the generator log "Weekly Generator System testing" with the Maintenance Director on 03/13/14 at 12:20 p.m., only the documentation for a monthly load test was available for review for the emergency generator for the months of August through October of</p>	K010144	"Weekly Generator System & Testing Records" (attachment # 6) The records were not found due to the facility has 2 Life Safety Manuals, facility in the process of combining into one Life Safety Manual. Maintenance Director will conduct audits (Attachment # 3 Revised) weekly for 4 weeks, then monthly thereafter and reported during QA Committee Meeting for further recommendations as needed.	04/12/2014			

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	<p>2013. Based on an interview with the Maintenance Director at the time of record review, he was unable to provide documentation of a weekly inspection for August through October of 2013.</p> <p>3.1-19(b)</p>			
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K010147 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 electrical switch boxes was maintained in a safe operating condition. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice was not in a resident area area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 03/13/14 at 1:22 p.m., the electrical relay switch in the water heater room lacked a cover. At the time of observation the Maintenance Director confirmed the switch was a relay and it had power.</p> <p>3.1-19(b)</p>			K010147	<p>Installed cover to electrical relay switch in water heater room.All residents have the potential to be affected.Installed cover to electrical relay switch in water heater room.Maintenance Director or Designee will conduct Monthly audit "Monthly Life Safety Checklist" (attachment # 2)Audit weekly (attachment # 3) x 4 weeks, then monthly thereafter.Audit results will be brought to monthly QA Meeting for additional recommendations if necessary</p>		04/12/2014

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K010154 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. in order to protect 34 of 34 residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. NFPA 25, A-11-5(c)2 states, "a fire watch should consist of trained personnel who continuously patrol the effected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important</p>	K010154	<p>New Policy and Procedure for Fire Watch (attachment # 7 Revised) placed in Disaster Plan Books.All residents have the potential to be affected.Updated Policy and Procedure placed in Disaster Plan Books.Maintenance Director or Designee will audit Disaster Plan Book (attachment # 3 Revised) every week for 4 weeks to assure appropriate Policy and Procedures are present in the book. Audit results will be brought to monthly QA Meeting for review and further recommendation if necessary</p>	04/12/2014			

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	<p>items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly." This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the "Policy and Procedure - Fire Alarm, Sprinkler, Generator, Phone Line Failure" with the Administrator and the Maintenance Director on 03/13/14 at 2:00 p.m., the facility's documentation provided for a plan of action when the automatic sprinkler system was out of service for more than four hours in a twenty four hour period was not complete. The procedure did not include all elements required such as the implementation of a fire watch if the fire alarm system is out of service for four hours in a twenty four hour period, training of staff to respond appropriately upon discovery of fire, the person conducting the fire watch shall have no other duties during that time and notification of the outage to the Indiana State Department of Health, local fire department, the insurance carrier and the automatic sprinkler system service company. Based on an interview with the</p>			
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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	<p>Administrator at the exit conference at 3:10, she was unable to provide any other documentation regarding the fire watch policy.</p> <p>3.1-19(b)</p>			
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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 03/13/2014	
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K010155 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview the facility failed to provide a complete written policy including procedures to be followed to protect 34 of 34 residents in the event the fire alarm system has to be placed out of service for four hours within a 24 hour period in accordance with LSC, Section 9.6.1.8. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review of the "Policy and Procedure - Fire Alarm, Sprinkler, Generator, Phone Line Failure" with the Administrator and the Maintenance Director on 03/13/14 at 2:00 p.m., the facility's documentation provided for a plan of action when the fire alarm system was out of service for more than four hours in a twenty four hour period was not complete. The procedure did not include all elements required such as the implementation of a fire watch if the fire alarm system is out of service for four</p>	K010155	<p>New Policy and Procedure for Fire Watch (attachment # 7 Revised) placed in Disaster Plan Books.All residents have the potential to be affected.Updated Policy and Procedure placed in Disaster Plan Books.Maintenance Director or Designee will audit Disaster Plan Book (attachment # 3 Revised) every week for 4 weeks to assure appropriate Policy and Procedures are present in the book. Audit results will be brought to monthly QA Meeting for review and further recommendation if necessary</p>	04/12/2014			

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	<p>hours in a twenty four hour period, training of staff to respond appropriately upon discovery of fire, the person conducting the fire watch shall have no other duties during that time and notification of the outage to the Indiana State Department of Health and the local fire department. Based on an interview with the Administrator at the exit conference at 3:10, she was unable to provide any other documentation regarding the fire watch policy.</p> <p>3.1-19(b)</p>			
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