STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155482		01/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENDALLVILLE MANOR	1802 E DOWLING ST KENDALLVILLE, IN 46755

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: January 11, 12, 13, 14 and 15, 2016 Facility number: 000529 Provider number: 155482 AIM number: 100267140 Census bed type: SNF/NF: 30 Total: 30 Census Payor type: Medicaid: 24 Other: 6 Total: 30 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. QR completed on January 19, 2016 by 17934.	F 0000	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.	
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified			

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

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 01/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENDALLVILLE MANOR	1802 E DOWLING ST KENDALLVILLE, IN 46755

(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
	persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure laboratory tests were obtained as ordered for 1 of 5 residents reviewed for unnecessary medications (Resident #7). The facility also failed to ensure a laboratory test was obtained as ordered for 1 of 3 residents reviewed for nutrition (Resident #31). Findings include: 1. The record for resident #7 was reviewed on 1/14/16 at 2:00 PM. Diagnoses included, but were not limited to, dementia and chronic bladder inflammation. A progress note by the facility nurse practitioner (NP), dated 12/22/2015, indicated "I am asked to see patient today at nurses (sic) request due to severe anxiety and crying which occurs nearly every afternoon.." Under "Assessment and Plan", the note further indicated "Will also obtain some labs to rule out other causes including UA (urinalysis)...." A Physician's Order, dated 12/22/2015, indicated a U/A and C&S (culture and sensitivity test to determine which antibiotic medication a urinary tract	F 0282	-What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: It is the practice of Kendallville Manor to follow facility policy in regards to performing Physician Orders in timely manner. -How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s)will be taken: -What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: -By what date the systemic changes will be completed: I. All of the residents were reviewed. Demographics of all KMHC residents have been reviewed and changed, if necessary, with the hospital lab computer program, to assure facility receives lab results timely. II. Laboratory orders will be entered into a “Lab Tracking Log” and monitored for completion of test on an ongoing monthly basis. III. The DON or designee will monitor the “Lab Tracking Log” every week for four weeks, then on an ongoing monthly basis thereafter to ensure completion of lab orders. After the audit of every week for four weeks, the DON will then review the Lab results on an ongoing monthly basis using the "Lab Tracking Log". Results of this audit will be	02/11/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155482		01/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENDALLVILLE MANOR	1802 E DOWLING ST KENDALLVILLE, IN 46755

(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
	infection [UTI] would be susceptible to) were ordered. There was no indication in Resident #7's record to indicate a UA or C&S had been obtained as ordered on 12/22/2015. A progress note by the facility NP, dated 12/29/2015, indicated "Patient is seen today in follow up from last weeks (sic) change in her medication to address her dementia and agitation with crying episodes." The note further indicated "Her UA has not been obtained as yet. Nursing staff will work on this." Under "Assessment and Plan", the note further indicated "Awaiting UA and C&S to ensure no infectious process at work." A physician's order, dated 12/29/2015, indicated "Please obtain a UA/C&S". A urinalysis report, dated 12/29/2015, indicated the U/A showed "trace" for leukocyte esterase (a urine test for the presence of white blood cells and other abnormalities associated with infection). The U/A report also indicated the reference range (normal) for leukocyte esterase was "negative." The U/A also indicated the test was positive for nitrites (a positive nitrite result indicates the cause of a UTI is commonly a gram negative organism). The U/A report		brought to QA Committee Meeting.	

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 01/15/2016
NAME OF PROVIDER OR SUPPLIER KENDALLVILLE MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 1802 E DOWLING ST KENDALLVILLE, IN 46755	

(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
	indicated the reference range for nitrates was negative. A physician order, dated 1/1/2016, indicated the Resident #7 was to receive Keflex (antibiotic) 500 milligrams three times daily for ten days. A care plan for Resident #7, with an initiation date of 1/1/2016 indicated "The resident has Urinary Tract Infection." A progress note by the facility NP, dated 1/5/2016, indicated "She has also been treated for a urinary tract infection with Keflex. It was hoped that treatment of her urinary tract infection would improve her crying and agitation however this has not occurred." The facility Director of Nursing (DON) was interviewed on 1/15/2016 at 9:30 A.M. During the interview, the DON indicated the U/A and C&S had not been obtained on 12/22/2015 as ordered. 2. The record for Resident #31 was reviewed on 1/14/2016 at 9:30 A.M. Diagnoses included, but were not limited to, diabetes mellitus (abnormal levels of glucose or blood sugar). A progress note by the facility nurse practitioner, dated 9/29/2015, indicated			

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 01/15/2016
NAME OF PROVIDER OR SUPPLIER KENDALLVILLE MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 1802 E DOWLING ST KENDALLVILLE, IN 46755	

(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
	"Patient is seen today for review of her chronic medical problems." The note further indicated "She also had some trouble with sugars that were elevated. Despite routine Novolog (medication used to treat diabetes) and lantus (medication used to treat diabetes). I did increase her lantus last week and add (sic) a sliding scale (routine blood tests to check blood sugar levels during the day, usually before meals and at bedtime). Most recent hemoglobin A1C (a blood test that shows the average blood glucose levels over the previous three months) on record is 5/4/15 at 7.9. The note further indicated under "Assessment and Plan" "Diabetes uncontrolled - will continue current lantus and sliding scale. Continue to check blood sugar levels QID (four times daily). Check hemoglobin A1C at next lab day." A Physician's Order, dated 9/29/2015, indicated a hemoglobin A1C was to be obtained the next lab day. A progress note by the facility nurse practitioner, dated 10/23/2015, indicated "Patient is seen today for review of her blood sugars and diabetes. I was called last night due to blood sugar > (greater than) 400. Patient has been receiving blood sugar checks QID (four times daily) with sliding scale. Blood sugars			

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 01/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENDALLVILLE MANOR	1802 E DOWLING ST KENDALLVILLE, IN 46755

(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
	fasting (before eating) have been in the 150 range but by lunch and throughout the rest of the day sugars are often >300." The note further indicated "Most recent hemoglobin A1C from May at 7.9 although I did order one for this month it is not on her record." The note indicated a hemoglobin A1C was to be obtained the next lab day. A Physician's Order, dated 10/23/2015, indicated a hemoglobin A1C was to be obtained the next lab day. A laboratory report, dated 10/25/2015, indicated Resident #31's hemoglobin A1C was 7.1 (reference range 4.0 - 5.7). A Physician's Order, dated 10/29/2015, indicated the resident's insulin was increased from 21 units of lantus daily at bedtime to 25 units at bedtime. A progress note by the facility nurse practitioner, dated 11/3/2015, indicated "She also had an adjustment in her insulin and blood sugars have decreased to 150-250 range." The facility Director of Nursing (DON) was interviewed on 1/14/2016 at 11:50 A.M. During the interview, the DON indicated nurses are to track when labs are ordered and then ensure the results			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155482		01/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENDALLVILLE MANOR	1802 E DOWLING ST KENDALLVILLE, IN 46755

(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
	are obtained back from the lab. The DON indicated the test for the glycohemoglobin A1C had been ordered on 9/29/2015, but the results had not been sent to the facility by the lab. 3.1-35(g)(2)			
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure a laboratory test was obtained as ordered for 1 of 3 residents reviewed for nutrition (Resident #31). Findings include: The record for Resident #31 was reviewed on 1/14/2016 at 9:30 A.M. Diagnoses included, but were not limited to, diabetes mellitus (abnormal levels of	F 0309	-What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: It is the practice of Kendallville Manor to follow facility policy in regards to performing Physician Orders in timely manner. -How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s)will be taken: -What measures will be put into place or what systemic changes will be made to ensure	02/11/2016

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 01/15/2016
NAME OF PROVIDER OR SUPPLIER KENDALLVILLE MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 1802 E DOWLING ST KENDALLVILLE, IN 46755	

(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
	glucose or blood sugar). A progress note by the facility nurse practitioner, dated 9/29/2015, indicated "Patient is seen today for review of her chronic medical problems." The note further indicated "She also had some trouble with sugars that were elevated. Despite routine Novolog (medication used to treat diabetes) and lantus (medication used to treat diabetes). I did increase her lantus last week and add (sic) a sliding scale (routine blood tests to check blood sugar levels during the day, usually before meals and at bedtime). Most recent hemoglobin A1C (a blood test that shows the average blood glucose levels over the previous three months) on record is 5/4/15 at 7.9. The note further indicated under "Assessment and Plan" "Diabetes uncontrolled - will continue current lantus and sliding scale. Continue to check blood sugar levels QID (four times daily). Check hemoglobin A1C at next lab day." A Physician's Order, dated 9/29/2015, indicated a hemoglobin A1C was to be obtained the next lab day. A progress note by the facility nurse practitioner, dated 10/23/2015, indicated "Patient is seen today for review of her blood sugars and diabetes. I was called		that the deficient practice does not recur: -By what date the systemic changes will be completed: I. All of the KMHC residents were reviewed. Demographics of all KMHC residents have been reviewed and changed, if necessary, with the hospital lab computer program, to assure facility receives lab results timely. II. Laboratory orders will be entered into a “Lab Tracking Log” and monitored for completion of test. III. The DON or designee will monitor the “Lab Tracking Log” every week for four weeks, then monthly thereafter to ensure completion of lab orders. After the audit of every week for four weeks, the DON will then review the Lab results on a monthly basis using the "Lab Tracking Log". Results of this audit will be brought to QA Committee Meetings for additional recommendations as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155482		01/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENDALLVILLE MANOR	1802 E DOWLING ST KENDALLVILLE, IN 46755

(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
	last night due to blood sugar > (greater than) 400. Patient has been receiving blood sugar checks QID (four times daily) with sliding scale. Blood sugars fasting (before eating) have been in the 150 range but by lunch and throughout the rest of the day sugars are often >300." The note further indicated "Most recent hemoglobin A1C from May at 7.9 although I did order one for this month it is not on her record." The note indicated a hemoglobin A1C was to be obtained the next lab day. A Physician's Order, dated 10/23/2015, indicated a hemoglobin A1C was to be obtained the next lab day. A laboratory report, dated 10/25/2015, indicated Resident #31's hemoglobin A1C was 7.1 (reference range 4.0 - 5.7). A Physician's Order, dated 10/29/2015, indicated the resident's insulin was increased from 21 units of lantus daily at bedtime to 25 units at bedtime. A progress note by the facility nurse practitioner, dated 11/3/2015, indicated "She also had an adjustment in her insulin and blood sugars have decreased to 150-250 range." The facility Director of Nursing (DON)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155482		01/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENDALLVILLE MANOR	1802 E DOWLING ST KENDALLVILLE, IN 46755

(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
	was interviewed on 1/14/2016 at 11:50 A.M. During the interview, the DON indicated nurses are to track when labs are ordered and then ensure the results are obtained back from the lab. The DON indicated the test for the glycohemoglobin A1C had been ordered on 9/29/2015, but the results had not been sent to the facility by the lab. 3.1-37(a)			
F 0315 SS=D Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on record review and interview, the facility failed to ensure laboratory tests were obtained as ordered for 1 of 5 residents reviewed for unnecessary medications (Resident #7). Findings include:	F 0315	-What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: It is the practice of Kendallville Manor to follow facility policy in regards to performing Physician Orders in timely manner. -How other residents having the potential to	02/11/2016

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 01/15/2016
NAME OF PROVIDER OR SUPPLIER KENDALLVILLE MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 1802 E DOWLING ST KENDALLVILLE, IN 46755	

(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
	1. The record for resident #7 was reviewed on 1/14/16 at 2:00 PM. Diagnoses included, but were not limited to, dementia and chronic bladder inflammation. A progress note by the facility nurse practitioner, dated 12/22/2015, indicated "I am asked to see patient today at nurses (sic) request due to severe anxiety and crying which occurs nearly every afternoon." Under "Assessment and Plan", the note further indicated "Will also obtain some labs to rule out other causes including UA (urinalysis, a test of the urine)...." A Physician's Order, dated 12/22/2015, indicated the nurse practitioner ordered a U/A and C&S (culture and sensitivity test to determine which antibiotic medication a urinary tract infection [UTI] would be best treated with). There was no indication in Resident #7's record to indicate a U/A had been obtained as ordered. A progress note by the facility nurse practitioner, dated 12/29/2015, indicated "Patient is seen today in follow up from last weeks (sic) change in her medication to address her dementia and agitation		be affected by the same deficient practice will be identified and what corrective action(s)will be taken: -What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: -By what date the systemic changes will be completed: I.All residents of KMHC were reviewed. Laboratory orders will be entered into a “Lab Tracking Log” and monitored for completion of test. II. The DON or designee will monitor the “Lab Tracking Log” every week for four weeks, then on an ongoing monthly basis to ensure completion of lab orders. Results of this audit will be brought to QA Committee Meeting.	

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 01/15/2016
NAME OF PROVIDER OR SUPPLIER KENDALLVILLE MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 1802 E DOWLING ST KENDALLVILLE, IN 46755	

(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
	with crying episodes." The note further indicated "Her UA has not been obtained as yet. Nursing staff will work on this." Under "Assessment and Plan", the note further indicated "Awaiting UA and C&S to ensure no infectious process at work." A physician's order, dated 12/29/2015, indicated "Please obtain a UA/C&S". A urinalysis report, dated 12/29/2015, indicated the UA showed "trace" for leukocyte esterase (a urine test for the presence of white blood cells and other abnormalities associated with infection). The urinalysis report also indicated the reference range (normal) for leukocyte esterase was "negative." The U/A also indicated the test was positive for nitrites (a positive nitrite result indicates the cause of a UTI is commonly a gram negative organism). The U/A report indicated the reference range for nitrates was negative. A physician order, dated 1/1/2016, indicated the resident was to receive Keflex (antibiotic) 500 milligrams three times daily for ten days. A care plan for Resident #7, with an initiation date of 1/1/2016 indicated "The resident has Urinary Tract Infection."			

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 01/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENDALLVILLE MANOR	1802 E DOWLING ST KENDALLVILLE, IN 46755

(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
	A progress note by the facility nurse practitioner, dated 1/5/2016, indicated "Patient is seen today in follow up from change in her medication to address her dementia and agitation with crying episodes. Last week I restarted her Risperdal (medication used to treat psychosis and delirium) at 0.25 mg (milligrams) daily. Staff report that this has helped some but she has continue (sic) to have much anger and hitting with care. She has also been treated for a urinary tract infection with Keflex." The facility Director of Nursing (DON) was interviewed on 1/15/2016 at 9:30 A.M. During the interview, the DON indicated the U/A and C&S had not been obtained as ordered on 12/22/2015. 3.1-41(a)(2)			
F 0325 SS=D Bldg. 00	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155482		01/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENDALLVILLE MANOR	1802 E DOWLING ST KENDALLVILLE, IN 46755

(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
	(2) Receives a therapeutic diet when there is a nutritional problem. Based on record review and interview, the facility failed to follow a recommendation for a laboratory test for 1 of 3 residents reviewed for nutrition (Resident #31). Findings include: The record for Resident #31 was reviewed on 1/14/2016 at 9:30 A.M. Diagnoses included, but were not limited to, diabetes mellitus and dementia. A "Nutrition Risk Assessment" by the facility Registered Dietitian (RD), dated 9/1/2015, indicated "New admit...." The note further indicated "Labs from May reviewed...." The note also indicated Alb (albumin) is noted to be low." The note further indicated the RD recommended the resident's pre-albumin (a blood test used to determine a person's nutritional status) level should be checked in one week. A care plan for Resident #31, with an initiation date of 9/3/2015, indicated the resident had a low albumin. There was no indication in Resident #31's record to indicate a pre-albumin had been	F 0325	-What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: It is the practice of Kendallville Manor to follow facility policy in regards to reviewing Registered Dietitian Recommendations and Obtaining Physician Orders in timely manner. -How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s)will be taken: -What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: -By what date the systemic changes will be completed: I. All residents were reviewed. Registered Dietitian and DON discussed deficiency of R.D. recommendations not being communicated on Consultant Report. II. R.D. will input “Nutrition Progress Reports” in PCC. III. R.D. and DON will print and review “Nutrition Progress Reports” in PCC and Consultant Report. IV. R.D. and DON will review upon R.D. exit from building. V. The DON or designee will monitor the “Nutrition Progress Reports” and Consultant Report every 2 weeks (Consultant in building every 2 weeks) for one month, then monthly thereafter to ensure continuity of R.D. recommendations is	02/11/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155482		01/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENDALLVILLE MANOR	1802 E DOWLING ST KENDALLVILLE, IN 46755

(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
	obtained as recommended by the RD on 8/21/2015. The facility Director of Nursing (DON) was interviewed on 1/14/2016 at 11:50 A.M. During the interview, the DON indicated the RD communicated any dietary recommendations to nursing on a consultation report so nursing could write the recommendation as a physician's order to be implemented. The DON indicated the RD's recommendation to obtain a pre-albumin had not been placed on the consultation report and had not been obtained as recommended. 3.1-46(a)(1)		communicated.	
F 0520 SS=C Bldg. 00	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are			

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 01/15/2016
NAME OF PROVIDER OR SUPPLIER KENDALLVILLE MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 1802 E DOWLING ST KENDALLVILLE, IN 46755	

(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
	necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on interview and record review, the facility failed to ensure the Medical Director attended quarterly quality assessment and assurance (QAA) committee meetings. Findings include: On 1/11/16 at 2:00 P.M., a requested list of QAA committee members was provide by the facility Administrator. The list did not include the Medical Director of the facility. An interview with Administrator on 1/15/16 at 2:15 P.M. indicated the Medical Director does not attend QAA meetings. **3.1-52(a)2)**	F 0520	I. Facility will coordinate its quarterly QA Meeting to fit in the rounding schedule with Medical Director. II. Next quarterly QA review will be April 7th, the day of his rounding at KMHC. III. Administrator or designee is responsible to ensure the Medical Director attends the quarterly QA Meetings.	02/11/2016

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 01/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENDALLVILLE MANOR	1802 E DOWLING ST KENDALLVILLE, IN 46755

(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