STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155482	A. BUILDING -- B. WING	02/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/21/23 Facility Number: 000529 Provider Number: 155482 AIM Number: 100267140 At this Emergency Preparedness survey, Kendallville Manor was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 60 certified beds. At the time of the survey, the census was 45. Quality Review completed on 02/23/23	E 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective March 9, 2023. We respectfully request paper compliance for this survey resolution.	
E 0041 SS=C Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Anthony L Hill	Senior Administrator	03/03/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain			

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	the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013.			

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	(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on records review and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 02/21/23 at 10:02 a.m., the generator lacked complete required testing in accordance with LSC and NFPA 110. Based on interview at the time of record review, the Maintenance Director stated the generator was missing some of the required testing. The findings were reviewed with the Maintenance Director at the exit conference.	E 0041	E 041 It is the policy of this facility that the generator be tested as required by state and federal guidelines. *The corrective action taken for those residents found to be affected by the deficient practice include:* All residents could be affected by loss of power and the generator not performing as required. *Other residents have the potential to be affected have been identified by:* All residents have the potential to be affected. *The measures of systemic changes that have been put in place to ensure that the deficient practice does not recur include:* Generator tests have been completed as required since the Senior Administrator and Maintenance Director started in August. The violation was from prior people in those roles not following through. We will continue to complete the tests as required. *The corrective action taken to monitor the performance to assure compliance through quality assurance is:* Maintenance Director is notified of the requirement and date of	03/09/2023

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			suspense by the automated TELS system which is also reviewed daily by the Administrator. Those test results will be printed and added to the monthly Quality Assurance Performance Improvement meeting for six months to ensure completion on time. Any issue that arises from the generator will be reported and fixed immediately. *The date the systemic change will be completed: 3/9/2023*	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/21/23 Facility Number: 000529 Provider Number: 155482 AIM Number: 100267140 At this Life Safety Code survey, Kendallville Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system	K 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective March 9, 2023. We respectfully request paper compliance for this survey resolution.	

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	with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 60 and had a census of 45 at the time of this survey. 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 Quality Review completed on 02/23/23			
K 0100 SS=F Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to maintain latching hardware on 2 of 2 corridor smoke barrier doors. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could all residents. Findings include: Based on observation with the Maintenance Director on 02/21/23 at 12:03 p.m. and 12:32 p.m., the two sets of smoke barrier doors in the resident halls were provided with latching hardware but failed to latch when tested. Based on interview at the time of observation, the Maintenance Director agreed the smoke doors were equipped with	K 0100	K 100 It is the practice of this facility that all smoke doors shut correctly and seal when closed. *The corrective action taken for those resident found to be affected by the deficient practice include:* All residents could be affected by loss of power and the generator not performing as required. *Other residents have the potential to be affected have been identified by:* All residents have the potential to be affected. *The measures of systemic*	03/09/2023

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	latching devices, but the doors did not properly latch when tested. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		*changes that have been put in place to ensure that the deficient practice does not recur include:* The door in question was adjusted on the day of survey, Feb 21, 2023, and works appropriately. A check of all fire doors is required with fire drills monthly. *The corrective action taken to monitor the performance to assure compliance through quality assurance is:* Fire drills and the outcomes of review of all smoke doors will be presented monthly to the QAPI interdisciplinary team for six months. Any negative findings will result in an additional month of review until 100% compliance is complete. *The date the systemic change will be completed: 3/9/2023*	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 4 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects 20 residents.	K 0211	211 It is the practice of this facility to keep hallways clear of hazards in relation to egresses. The corrective action taken for those residents found to be	03/09/2023

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	Findings include: Based on an observation during a tour of the facility with the Maintenance Director 02/21/23 at 12:30 p.m., in the short hall exit corridor by the nurse's station there was a wheelchair scale against the wall protruding into the corridor about 4-feet. Based on an interview at the time of observations, the Maintenance Director stated the scale was in an exit corridor and will be moved. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		affected by the deficient practice include: No residents were affected. Other residents that have the potential to be affected have been identified by: All residents have the potential to be affected. The measures of systemtic changes that have been put into place to ensure that the deficient practice does not recur include: The scale in question was moved day of survey to an appropriate setting for resident movement, 2/21/2023. A daily audit of hallway safety was created. The corrective action taken to monitor the performance to assure compliance though quality assurance is: Daily audit will be reviewed weekly by Admin. Results will be shared in QAPI at monthly meeting for six months. Any deviation from guidelines will be rectified immediately. Date of compliance: 3/9/2023	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on records review and interview, the facility failed to ensure 4 of 4 battery backup lights were tested monthly. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly,	K 0291	K 291 It is the policy of this facility that the emergency lights be tested as required by state and federal	03/09/2023

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	with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all building occupants when work is needed in the transfer switch room during a power outage. Findings include: Based on records review with the Maintenance Director on 02/21/23 at 10:23 a.m., there was no monthly testing of the Emergence Battery Powered Lighting for the months of May 2022 through August 2022. During an interview at the time of record review, the Maintenance Director stated the previous Maintenance Director did not complete the required inspections and testing. The finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		guidelines. *The corrective action taken for those residents found to be affected by the deficient practice include:* All residents could be affected by loss of power and the emergency battery powered lights not performing as required. *Other residents have the potential to be affected have been identified by:* All residents have the potential to be affected. *The measures of systemic changes that have been put in place to ensure that the deficient practice does not recur include:* Emergency battery powered light tests have been completed as required since the Senior Administrator and Maintenance Director started in August. The violation was from prior people in those roles not following through. We will continue to complete the tests as required. *The corrective action taken to monitor the performance to assure compliance through quality assurance is:* Maintenance Director is notified of the requirement and date of suspense by the automated TELS system which is also reviewed daily by the Administrator. Those test results will be printed and added to the monthly Quality Assurance Performance Improvement meeting for six	

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			months to ensure completion on time. Any issue that arises from the emergency battery powered lights will be reported and fixed immediately. *The date the systemic change will be completed: 3/9/2023*	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.			
	Based on record review and interview, the facility failed to ensure documentation for the preventative maintenance of 30 of 30 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on records review with the Maintenance Director on 02/21/23 at 10:49 a.m., there was no	K 0300	K 300 It is the policy of this facility that the battery powered smoke alarms be tested as required by state and federal guidelines. *The corrective action taken for those residents found to be affected by the deficient practice include:* All residents could be affected by loss of power and the battery powered smoke alarms not performing as required. *Other residents have the potential to be affected have been identified by:* All residents have the potential to be affected. *The measures of systemic changes that have been put in place to ensure that the deficient practice does not recur include:*	03/09/2023

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	testing of the 30-resident room Battery Powered Smoke Alarms for the months of May 2022 through August 2022. During an interview at the time of record review, the Maintenance Director stated the previous Maintenance Director did not complete the required inspections and testing. The finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		Battery powered smoke alarm tests have been completed as required since the Senior Administrator and Maintenance Director started in August. The violation was from prior people in those roles not following through. We will continue to complete the tests as required. *The corrective action taken to monitor the performance to assure compliance through quality assurance is:* Maintenance Director is notified of the requirement and date of suspense by the automated TELS system which is also reviewed daily by the Administrator. Those test results will be printed and added to the monthly Quality Assurance Performance Improvement meeting for six months to ensure completion on time. Any issue that arises from the battery powered smoke alarms will be reported and fixed immediately. *The date the systemic change will be completed: 3/9/2023*	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has			

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	been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty-four-hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review with the Maintenance Director on 02/21/23 at 11:51 a.m., the fire watch plan failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Maintenance Director acknowledged the fire watch documentation provided stated to contact the IDOH but not via the IDOH Gateway link or at the e-mail address listed above. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)	K 0346	K 346 It is the policy of this facility that IDOH be notified of a failed fire alarm system. *The corrective action taken for those residents found to be affected by the deficient practice include:* No residents were affected by this alleged deficiency. *Other residents that have the potential to be affected have been identified by:* Residents have no potential harm involved with this deficiency. *The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:* Policy was in EPP and is dated May 21, 2019, it includes the cited omitted section. *The corrective action taken to monitor the performance to assure compliance through quality assurance is:* Policies are reviewed semi-annually and signed off by the IDT. This policy is included in those reviews. The date of systemic change will be completed: 3/9/2023	03/09/2023
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in			

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	accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly, or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 2/21/23 at 10:13 a.m., there was no weekly inspection of the dry sprinkler system's	K 0353	K353 It is the practice of this facility to ensure there are no hazardous conditions in any area of the facility. *The corrective action taken for those residents found to be affected by the deficient practice include:* All residents could be affected by a delay in the sprinkler system operating. *Other residents that have the potential to be affected have been identified by:* All residents have the potential to be affected. *The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:* Weekly inspections of the dry sprinkler system have been completed as required since the	03/09/2023

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

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	gauges and no monthly inspection of the wet pipe sprinkler system's gauges and valves for the months of May 2022 through August 2022. During an interview at the time of record review, the Maintenance Director stated the previous Maintenance Director did not complete the required inspections. The finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		Senior Administrator and Maintenance Director started in August. The violation was from prior people in those roles not following through. We will continue to complete the tests as required. *The corrective action taken to monitor the performance to assure compliance through quality assurance is:* The Maintenance Director is responsible for completing the weekly testing. Those results will be submitted to the Administrator weekly and included in Quality Assurance Process Improvement meeting monthly for six months. Any deviation from the state guideline will be addressed immediately. *The date the systemic change will be completed: 3/9/2023*	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been			

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	returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that 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 occupants in the facility. Findings include: Based on records review with the Maintenance Director on 02/21/23 at 11:51 a.m., the fire watch plan failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Maintenance Director acknowledged the fire watch documentation provided stated to contact the IDOH but not via	K 0354	K354 It is the practice of this facility to report a loss of the sprinkler system to IDOH as required. *The corrective action taken for those residents found to be affected by the deficient practice include:* No residents were affected by this alleged deficiency. *Other residents that have the potential to be affected have been identified by:* No residents have the potential to be affected. *The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:* The Fire Watch Policy was in the EPP dated May 21, 2019 and includes the email instructions for notifying IDOH of any loss of the sprinkler system following the guidelines of NFPA 25, 2011 Edition. *The corrective action taken to monitor the performance to assure compliance through quality assurance is:* All policies are reviewed for updates and accuracy bi-annually including this one and signed off by the IDT. *The date the systemic change will be completed: 3/9/2023*	03/09/2023

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	the IDOH Gateway link or at the e-mail address listed above. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)			
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is			

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	sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of 30 resident room corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 residents in room 114. Findings include: Based on observation with the Maintenance Director on 02/21/23 at 12:13 p.m., the corridor door to resident room 114 did not latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director stated the corridor door would not latch into the door frame and needed to be adjusted. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)	K 0363	K363 It is the practice of this facility to ensure that all doors are complete and meet required fire ratings. *The corrective action taken for those residents found to be affected by the deficient practice include:* All residents in this hall have the potential to be affected. *Other residents that have the potential to be affected have been identified by:* All residents on this hall have the potential to be affected. *The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:* Door 114 was adjusted on the date of survey, Feb 21. 2023, and works correctly. *The corrective action taken to monitor the performance to assure compliance through quality assurance is:* Maintenance Director or designee is responsible for ensuring all doors are complete and shut	03/09/2023

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			properly. A weekly audit of doors will be completed that includes ensuring there are no doors that do not fully close. Those results will be submitted to the Administrator weekly and included in Quality Assurance Process Improvement meeting monthly for six months. Any deviation from the state guideline will be addressed immediately. *The date the systemic change will be completed: 3/9/2023*	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct fire drills on each shift for 3 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents. Findings include:	K 0712	K 712 It is the practice of this facility that fire drills be completed as required by state and federal guidelines. *The corrective action taken for those residents found to be affected by the deficient practice include:* No residents were affected by this deficiency. *Other residents that have the*	03/09/2023

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	Based on records review with the Maintenance Director on 02/21/23 at 10:51 a.m., the following shifts were missing documentation of a completed fire drill: a) All shift's fire drills in second quarter of 2022. b) All shift's fire drills in third quarter of 2022. c) All shift's fire drills in fourth quarter of 2022. During an interview at the time of record review, the Maintenance Director stated the previous Maintenance Director did not complete the second and third quarter fire drills and the fourth quarter was missed because the new Maintenance Director did not know how to operate the fire alarm system. The finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)		*potential to be affected have been identified by:* All residents have the potential to be affected. *The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:* Fire Drills have been completed as required since the Senior Administrator and Maintenance Director started in August. The violation was from prior people in those roles not following through. We will continue to complete the tests as required. *The corrective action taken to monitor the performance to assure compliance through quality assurance is:* The Maintenance Director is responsible for completing the fire drills. Those results will be submitted to the Administrator and included in Quality Assurance Process Improvement meeting monthly for six months. Any deviation from the state guideline will be addressed immediately. *The date the systemic change will be completed: 3/9/2023*	
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after			

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	initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)			
	Based on observation, record review and interview, the facility failed to ensure non-hospital grade electrical receptacles at 50 of 50 resident sleeping rooms were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4	K 0914	K 914 It is the practice of this facility that receptacles be tested in resident rooms as is required by state and federal guidelines. *The corrective action taken for those residents found to be affected by the deficient practice:* Residents with non hospital grade receptacles could be affected. *Other residents that have the potential to be affected have been identified by:* All residents with non hospital grade receptacles in their rooms have the potential to be affected. *The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur:*	03/09/2023

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	ounces). This deficient practice could affect all residents. Findings include: Based on observations with the Maintenance Director on 02/21/23 between 12:00 p.m. and 1:00 p.m., the facility's 50 resident sleeping rooms contained four to eight non-hospital-grade electrical receptacles. Based on records review at 11:30 a.m., no documentation was available to show the electrical receptacles in resident sleeping rooms were tested in 2022. Based on interview at the time of the observation and records review, the Maintenance Director confirmed all the electrical receptacles in the resident sleeping rooms were not hospital-grade and stated the previous Maintenance Director did not complete the required testing for 2022. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		A complete review of all receptacles in all resident rooms was completed with no deficiencies noted. *The corrective action taken to monitor the performance to assure compliance through quality assurance is:* Annual review of all receptacles is required and has been added to TELS as an annual inspection to be completed each January. Those records will be accessible through TELS and also printed and included in QAPI moving forward. Date of Compliance: 3/9/2023	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly,			

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	exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 12 months and weekly inspection for 5 of 52 weeks. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Section 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the	K 0918	K 918 It is the policy of this facility that the generator load be tested as required by state and federal guidelines. *The corrective action taken for those residents found to be affected by the deficient practice include:* All residents could be affected by loss of power and the generator not performing as required. *Other residents have the potential to be affected have been identified by:* All residents have the potential to be affected.	03/09/2023

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	generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 02/21/23 at 10:03 a.m., there was no weekly inspection and no monthly load test of the Emergence Powered Generator for the months of May 2022 through August 2022. During an interview at the time of record review, the Maintenance Director stated the previous Maintenance Director did not complete the required inspections and testing. The finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		*The measures of systemic changes that have been put in place to ensure that the deficient practice does not recur include:* Generator load tests have been completed as required since the Senior Administrator and Maintenance Director started in August. The violation was from prior people in those roles not following through. We will continue to complete the tests as required. *The corrective action taken to monitor the performance to assure compliance through quality assurance is:* Maintenance Director is notified of the requirement and date of suspense by the automated TELS system which is also reviewed daily by the Administrator. Those test results will be printed and added to the monthly Quality Assurance Performance Improvement meeting for six months to ensure completion on time. Any issue that arises from the generator load test will be reported and fixed immediately. *The date the systemic change will be completed: 3/9/2023*	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed,			

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	and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure a minimum distance of at least five feet separated combustible materials from oxygen	K 0923	K 923 It is the practice of this facility that flammable items not be stored in	03/09/2023

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KENDALLVILLE MANOR	1802 E DOWLING ST KENDALLVILLE, IN 46755

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	storage equipment in 1 of 1 oxygen storage areas. NFPA 99, 11.3.2.3 requires oxidizing gases such as oxygen shall be separated from combustibles by one of the following: (1) a minimum distance of 20 feet. (2) a minimum distance of 5 feet if the required storage location is protected by an automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. This deficient practice could affect 20 resident in one smoke compartments. Findings include: Based on observation with the Maintenance Director on 02/21/23 at 12:59 p.m., five cardboard boxes containing supplies were stored within five feet of stationary liquid oxygen containers in the oxygen storage and trans-filling room. Also, the oxygen storage and trans-filling room had combustible paneling on three of the four walls Based on interview at the time of observation, the Maintenance Director agreed combustible materials were stored within five feet of stationary liquid oxygen containers and there was combustible paneling on the walls. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		the oxygen room. *The corrective action taken for those residents found to be affected by the deficient practice include:* No residents were affected by this deficiency. *Other residents that have the potential to be affected have been identified by:* All residents have the potential to be affected by the possibility of a fire. *The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:* All flammable items were removed from the oxygen room on the day of survey, Feb 21, 2023. A notice was placed on the door and an in-service was completed with all nursing staff of this requirement. *The corrective action taken to monitor the performance to assure compliance through quality assurance is:* A weekly audit of the oxygen room will be performed for six months. The results of those audits will be presented to the Quality Assurance Process Improvement Committee at the monthly meeting. Any deficiencies will be corrected immediately. *The date the systemic change will be completed: 3/9/2023*	