STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155482	A. BUILDING 00 B. WING	03/22/2023

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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00403856. Complaint IN00403856 - Federal/state deficiencies related to the allegations are cited at F604. Survey date: March 22, 2023 Facility number: 000529 Provider number: 155482 AIM number: 100267140 Census Bed Type: SNF/NF: 46 Total: 46 Census Payor Type: Medicare: 4 Medicaid: 33 Other: 9 Total: 46 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 23, 2023	F 0000		
F 0604 SS=D Bldg. 00	483.10(e)(1), 483.12(a)(2) Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Anthony L Hill | Senior Administrator | 03/31/2023

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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	symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. Based on interview and record review, the facility failed to ensure a resident was free from physical restraints for 1 of 1 residents reviewed (Resident B). Findings include: A facility reported incident to the Indiana Department of Health, dated 3/11/23 at 1:06 p.m., indicated Resident B had been secured in her wheelchair with use of a gait belt. On 3/22/23 at 10:15 A.M., Resident B's record was reviewed. Diagnoses included recent hemorrhagic stroke (brain bleed), altered mental status, and diabetes.	F 0604	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 request that the plan of correction be considered our allegation of compliance effective March 31, 2023, for the complaint survey completed March 22, 2023. Kendallville Manor would like to respectfully request a desk review/paper compliance of this	03/31/2023

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	An admission MDS (Minimum Data Set) assessment, dated 3/13/23, indicated the resident had severely impaired cognition. Her speech was clear and able to be understood. She had no hallucinations or delusions but had 1-3 days of physical behaviors towards others. She required extensive assistance from 2 staff for transfers, bed mobility, and toileting. An initial fall care plan, dated 3/8/23, indicated the resident was at high risk for falls due to being unaware of safety needs with history of falls. Interventions included: anticipate and meet the residents needs, follow fall protocol, therapy to evaluate and treat, and use a bed/chair alarm. A physician order, dated 3/6/23, indicated the resident was to participate in activities, social, nursing and restorative, therapy, and psychosocial programs as tolerated. There was no order for a physical restraint. Nurse progress notes indicated: -3/7/23 at 4:55 p.m., a Nurse Practitioner (NP) note indicated the resident had poor safety and environmental awareness due to a hemorrhagic stroke. This put her at high risk for falls and/or injuries. -3/9/23 at 8:10 p.m., the resident had a fall in the hallway after standing up from her wheelchair. -3/10/23 at 10:01 a.m., the resident had a fall the previous evening when she had been agitated and kept attempting to get up by herself. Fall interventions were for the NP to review her medications and check labs. At 1:58 p.m., the resident was alert but disoriented. She was wheelchair dependent but		plan of correction. F604 Right to be Free from Physical Restraints It is the practice of this facility to ensure that residents are free from physical restraints. · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident B had the gait belt removed from her waist by the Director of Therapy. The staff involved were immediately removed from the schedule after notification to management. · 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: All residents have the potential to be affected by the deficient practice. Facility wide interviews of all residents and staff were conducted with no additional restraint use identified. For those residents unable to be interviewed, families were interviewed regarding their knowledge of any restraint use in the facility with no issues identified. Skin checks were also completed on all residents with no injuries of unknown source noted. · What measures will be put	

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	could stand and then would fall. At 9:24 p.m., the resident was continuously getting out of her chair. -3/11/23 at 4:37 p.m., staff had secured Resident B into her wheelchair because she had been unsteady on her feet. She was released from the gait belt that secured her in the chair and was assessed with no injuries observed. Staff involved in the incident were removed from the schedule and family and physician were notified. A facility investigation, initiated on 3/11/23 indicated RN 2 (Registered Nurse) instructed QMA 3 (Qualified Medication Aide) to assist her in placing a gait belt around Resident B's abdomen and wheelchair. The gait belt was secured at the back of the resident's wheelchair where she was unable to reach it. A written statement by RN 2, dated 3/11/23 indicated she and QMA 3 placed the gait belt around the resident and her wheelchair at 7:25 a.m. The resident kept standing up and she believed it was safer for the resident rather than she falling and sustaining injury. She indicated she had needed to get her medications passed and had a job to do. A written statement by QMA 3, dated 3/11/23 indicated she had followed the direction of her nurse-RN 2, to assist her in placing a gait belt around the resident and her wheelchair at 7:25 a.m. Resident B was repeatedly standing, sitting and would not stay seated. QMA 3 believed she was going to fall and get hurt. She indicated everyone was busy trying to do their jobs and protect her. On 3/22/23 at 11:18 A.M., Resident B and her spouse were interviewed. Her speech was clear		into place and what systemic changes will be made to ensure that the deficient practice does not recur: The facility policy on abuse, which includes the use of restraints, was reviewed by the IDT. An in-service was conducted with all facility staff on the policy. A performance improvement tool has been developed to monitor that residents are free of restraint use, understanding of the abuse policy and proper reporting. · How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A Quality Assurance tool has been developed and implemented that randomly audits (5) five staff and residents, or families of residents unable to be interviewed, that residents are free of restraint use, employees have the knowledge of what constitutes a restraint and proper reporting is followed. This tool will be completed by the Administrator and/or his designee weekly times four, then monthly times three and then quarterly times three. The outcomes will be reviewed through the facility Quality Assurance Program. Additional action will be taken by the Quality Assurance Committee if warranted.	

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	and easily understood. She had no memory of having a gait belt placed around her in her wheelchair. Her spouse indicated the resident had some improvements with her memory and her anxiety had decreased but she continued with intermittent confusion. On 3/22/23 at 1:07 P.M., the Director of Therapy was interviewed. She indicated on 3/11/23 at approximately 7:40 a.m., RN 2 told her she had placed a gait belt around Resident B because she kept trying to get up from her wheelchair. RN 2 was stressed and indicated she knew they weren't supposed to restrain the residents but she needed to get things done and was unable to sit with the resident. The Therapy Director indicated she went to the dining room where the resident sat and assisted her to eat her breakfast. After breakfast, she took the resident to the therapy room, removed the gait belt and placed her in a different wheelchair. She then contacted the Director of Nursing to report the incident. She indicated the resident had the gait belt around her for 45-60 minutes and hadn't seemed to notice something was around her waist. On 3/22/23 at 2:45 P.M., the Director of Nursing was interviewed. She indicated on 3/11/23, during the day shift when the incident occurred, the facility was fully staffed with 2 RN's, 1 QMA, and 5 CNA's working and caring for 46 residents. She indicated staff were never allowed to restrain a resident for purposes of convenience. RN 2 and QMA 3 were both terminated for their actions. A current "Abuse Policy", provided by the Administrator on 3/22/23 at 9:40 A.M., stated the following: "The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation...This includes but is		- · By what date the systemic changes for the deficiency will be completed: March 31, 2023	

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	not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms...Definitions: Convenience is defined as the result of any action that has the effect of altering a resident's behavior such that the resident requires a lesser amount of effort or care, and is not in the resident's best interest...Physical restraint is defined as any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria: Is attached or adjacent to the resident's body; Cannot be removed easily by the resident; and Restricts the resident's freedom of movement or normal access to his/her body...." This Federal tag relates to Complaint IN00403856. 3.1-3(w)			