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	02/07/2024

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00426221. Complaint IN00426221 - No deficiencies related to the allegations are cited. Survey dates: February 2, 5, 6 and 7, 2024. Facility number: 000529 Provider number: 155482 AIM number: 100267140 Census Bed Type: SNF/NF: 50 Total: 50 Census Payor Type: Medicare: 2 Medicaid: 37 Other: 11 Total: 50 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 8, 2024	F 0000	F 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 February 21, 2024, for annual survey completed February 7, 2024. We respectfully request a resolution of paper compliance/bench review for this survey.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
celeste morgan	RN DON	02/20/2024

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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	§483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review the facility failed to ensure medications were secured for 1 of 4 residents reviewed (Resident 17). Findings include: During an observation on 2/6/24 at 8:36 AM a cup containing 6 white pills was observed sitting on top of the medication cart beside a cup containing applesauce. The pills were in plain sight of anyone passing by the cart. No staff member was attending to the cart. 3 unidentified residents passed by during the observation. During an observation and interview on 2/6/24 at 8:39 AM, the Administrator shook his head when informed of the presence of pills accessible on top of the cart and indicated he would stay at the cart	F 0761	F 0761 Label/Store Drugs and Biologicals It is the practice of this facility to ensure medications are kept secured for all residents. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Administrator monitored the medication cart until QMA 4 returned. The medication was then dispensed to resident 17. 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 who are dispensed medication by the facility have the	02/21/2024

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	and supervise the pills until the staff member in charge of the cart returned to the area. Resident 17's record was reviewed on 2/6/24 at 9:55 AM. Diagnoses included cerebral palsy, chronic obstructive pulmonary disease, and aphasia. Resident 17's current quarterly Minimum Data Set (MDS) dated 12/11/23 indicated his Basic Interview for Mental Status (BIMS) score was 7 (cognitively impaired). Current physician's orders included orders for the following medications to be administered at 9:00 AM on 2/6/24: Bumex 1 mg, 1 tablet (a diuretic, or medication to release excess fluid from the body) Simethicone 80 mg, 2 tablets (digestive aid) Buspirone 10 mg, 1 tablet (anti-anxiety medication) Lamotrigine 25 mg, 2 tablets (anti-convulsant or seizure medication). In an interview on 2/6/23 at 9:09 AM, the Director of Nursing (DON) indicated staff should not leave pills unattended on top of the medication cart. She indicated she had interviewed Qualified Medicine Aide (QMA)4. She indicated QMA 4 had prepared the medication for Resident 17 and left the cart to assist another staff member. A current policy titled Medication Administration General Guidelines dated 5/20/20 provided by the DON on 2/4/24 at 10:04 AM indicated medications should not be left on top of the cart unattended. 3.1-25 (m)		potential to be affected by the alleged deficient practice. A medication pass observation was conducted with all facility nurses and QMA's with no further deficiencies in leaving medication unattended. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The policy "Medication Administration General Guidelines" was reviewed by the IDT. An in-service was held with all licensed nurses and QMA's on the policy for medication administration including not leaving medications unattended. A quality assurance audit tool has been developed to monitor that medications are not left unattended during medication administration. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Quality Assurance Audit Tool will be completed by the Director of Nursing /Designee on all licensed nurses and QMA's for 5 residents weekly for three weeks, then monthly for three months, then quarterly x three to ensure medications are not left unattended during medication pass. In the event any further concerns are identified, the issue will be immediately corrected, and	

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			additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting monthly. By February 19, 2024	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review the facility failed to ensure dishwasher chemical checks were completed consistently. 47 of 50 residents residing in the facility were served food prepared in the kitchen. Findings include:	F 0812	F 812 Food Procurement, Store/Prepare/Serve-Sanitary It is the practice of this facility to ensure that dishwashing is in accordance with professional standards for food service safety. What corrective action(s) will be accomplished for those residents found to have been affected by the	02/21/2024

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	During an observation and interview on 2/2/24 at 9:57 AM, Cook 3 was observed washing dishes in the dishwasher. The Dietary Manager (DM) indicated he was unable to locate the test strips to test the dishwasher sanitizer levels. In a record review beginning 2/2/24 at 9:55 AM a document titled "Dishwashing temp (temperature)/PPM (parts per million) Feb (February) 2024" was reviewed. The document contained a grid with dates and columns labeled breakfast reading/initial, lunch reading/initial, and dinner reading/initial. The document indicated the temperature should be 120-140 degrees and PPM should be 50-100. The 2/1/24 breakfast temperature reading was 121, but no ppm reading was recorded. The 2/1/24 lunch temperature reading was 125, but no ppm reading was recorded. No ppm readings were recorded for 2/1/24 dinner or 2/2/24 breakfast. In an interview, on 2/2/24 at 9:57 AM, Cook 3 indicated the employee assigned to do the dishes was assigned to fill out the dishwasher log. She indicated she was frequently assigned to do the dishes, but she did not know how to test the chemicals. In an observation and interview, on 2/2/24 at 12:11 PM, the DM indicated he had obtained test strips from another facility. During the chemical test, the strips registered 0 ppm. In an observation and interview, on 2/2/24 at 1:10 PM, the DM indicated he had used incorrect strips on the previous test. The test strips were labeled QT Hydrion and had 5 color indicator strips. The strips were labeled 0, 150, 200, 400, and 500. The DM indicated he was unable to		deficient practice: The correct strips to measure chlorine were ordered on 2/2/24 when this issue was identified, and the correct strips were in place and being used on 2/3/24. No dishes were washed in the dishwasher until the correct sanitizer strength of 50-100 ppm was reached. 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 who consume meals in the facility have the potential of being affected by the alleged deficient practice: Dishwasher temps and PPM are monitored each meal cycle and documented on a log by staff. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The policy “Dish Machine Temperatures and Sanitizer Testing” was reviewed by the IDT. An in-service was held with all dietary staff on the policy and method to monitor and log the dishwasher temperature and PPM. The policy “Dish Machine Temperatures and Sanitizer Testing” was reviewed by the IDT. An in-service was held with all dietary staff on the policy and method to monitor and log the dishwasher temperature and PPM.	

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	determine whether the PPM reading was between 50 and 100, so he estimated a reading. A current policy titled Dish Machine Temperatures (Low Temperature Machines) and Sanitizer Testing dated 7/2003 provided by the DM on 2/2/24 at 10:07 AM indicated the dish machine should be checked at each meal cycle using a chlorine test strip. Sanitizer strength should be 50-100 PPM hypochlorite. 3.1-21(i)3		A quality assurance audit tool has been developed to monitor that the dishwasher temperature and PPM are within acceptable range. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: A performance improvement tool has been initiated that randomly checks the log and the usage of the strips. This Quality Assurance Audit Tool will be completed by the Director of Nutrition Services for 5 meals weekly for three weeks: then monthly for three months, then quarterly x three. In the event any further concerns are identified, the issue will be immediately corrected, and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting monthly. By what date the systemic changes for each deficiency will be completed: February 19, 2024	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review the facility failed to ensure the facility was maintained in a clean and sanitary manner for 2 of	F 0921	F 912 Safe/Functional/Sanitary/Comforta ble Environment It is the practice of this facility to	02/21/2024

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	24 residents reviewed (Resident 30 and Resident 31). Findings include: 1. During an observation on 2/5/24 at 9:23 AM, a urinal containing 150 ml of yellow fluid was observed on the bedside stand beside Resident 30's bed. Resident 30's mattress was uncovered, and no linens were on the bed. Resident 30's roommate indicated Resident 30 had left the building for some appointments and was not expected to return until around 5:00 PM. During an observation on 2/5/24 at 10:47 AM, an unidentified housekeeper was observed cleaning Resident 30's room. The urinal, containing the yellow fluid, was visible from the doorway in the same position on the bedside stand. During an observation on 2/5/24 at 1:49 PM, Resident 30's bed was made up with linens and the urinal, with yellow fluid, was observed on the bedside stand. During an observation and interview on 2/5/24 at 2:30 PM, Qualified Medicine Aide (QMA) 2 indicated the urinal should have been emptied and put away. During an interview on 2/6/24 at 2:41 PM, Resident 30 indicated he had left the building around 8:00 AM on 2/5/24 to attend appointments and returned around 5:00 PM. Resident 30's record was reviewed on 2/7/24 at 9:40 AM. Diagnoses included chronic kidney disease stage 5, diabetes mellitus with foot ulcer, and dependence on renal dialysis.		ensure that residents reside in a clean and sanitary environment. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Upon notification, resident #30 urinal was emptied, cleaned, dried and stored and the brown substance was cleaned from the wall in resident #31 room. 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 who reside in the facility have the potential to be affected by the alleged deficient practice. An audit was completed on all residents' rooms to ensure no further cleanliness or sanitary concerns were noted with no further issues identified. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The policies titles "Bedpan/Urinal Offering/Removing" and "Cleaning Spills or Splashes of Blood or Body Fluids" were reviewed by the IDT. An in-service was held with the nursing staff on 2/5/24 on the policy for emptying urinals promptly after use. An in-service was held with the housekeeping staff on 2/6/24 on the policy for cleaning body fluids from surfaces. A quality assurance audit tool has	

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	Resident 30's current quarterly Minimum Data Set (MDS), dated 11/15/23, indicated his Basic Interview for Mental Status (BIMS) score was 15 (cognitively intact). In an interview, on 2/5/24 at 2:33 PM, the Director of Nursing (DON) indicated residents who could independently use urinals should be checked for needs at least every 2 hours. She indicated staff who are in the room to clean or make the bed should empty and clean urinals when they had been used. A current policy titled Bedpan/Urinal Offering/Removing dated 2/2018 provided by the Director of Nursing (DON) indicated urinals should be emptied, cleaned, dried, and put away after use. 2. During an observation in Resident 31's room on 2/2/24 at 2:40 PM, a dark brown substance measuring about 2 inches by 4 inches was viewed on the wall adjacent to the bathroom, about 2 feet from the bathroom door and about 6 inches from the floor. When standing next to the wall, a smell consistent with bowel movement was detected. During an observation in Resident 31's room on 2/5/24 at 10:18 AM, a dark brown substance was viewed on the wall in the same location as the 2/2/24 observation with a slightly smaller and darker appearance. During an observation and interview on 2/5/24 at 2:30 PM Qualified Medicine Aide (QMA) 2 indicated the substance in Resident 31's room appeared to be dried bowel movement and should have been cleaned off the wall. Resident 31's record was reviewed on 2/7/24 at		been developed to monitor that urinals are emptied promptly, and resident walls are free of bodily fluids as per housekeeping checklist. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: A performance improvement tool has been initiated that randomly checks five (5) resident rooms to ensure all items on the daily checklist are completed, which includes urinals being emptied and walls free of bodily fluids. The Administrator or designee will complete this audit weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified, the issue will be immediately corrected, and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least monthly. By what date the systemic changes for each deficiency will be completed: February 19, 2024	

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	10:10 AM. Diagnoses included schizophrenia, post-traumatic stress disorder, chronic, and chondrocostal junction syndrome. A review of Resident 31's current Minimum Data Set (MDS) dated 12/1/23 indicated her Basic Interview for Mental Status (BIMS) score was 15 (cognitively intact). The MDS indicated Resident 31 used substantial assistance with toileting hygiene. In an interview on 2/5/24 at 2:33 PM, the DON indicated walls in resident rooms should be clean and staff should wash off any visible debris when present. A current policy titled Cleaning Spills or Splashes of Blood or Body Fluids dated 1/2012 provided by the Assistant Director of Nursing (ADON) on 2/6/24 at 10:23 AM indicated appropriately trained staff should clean any surfaces contaminated with body fluids as soon as practical to prevent exposure. 3.1-19(f)5			