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	02/29/2024

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/29/24 Facility Number: 000529 Provider Number: 155482 AIM Number: 100267140 At this Emergency Preparedness survey, Kendallville Manor was found in 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 52. Quality Review completed on 03/05/24	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 13, 2024. We respectfully request paper compliance for this survey resolution.	
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: 02/29/24 Facility Number: 000529 Provider Number: 155482 AIM Number: 100267140 At this Life Safety Code survey, Kendallville Manor was found not in compliance with	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 13, 2024. We respectfully	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Anthony L Hill	Senior Administrator	03/13/2024

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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	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 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 52 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 03/05/24		request paper compliance for this survey resolution.	
K 0341 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity.			

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	18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was continuously in proper operating condition. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation of the fire alarm control panel with the Maintenance Director on 02/29/24 at 11:05 a.m., the time and date on the display of the fire alarm control panel indicated the time and date was 11:50 a.m. 04/06/15 when checked at 10:44 a.m. on 02/09/24. Based on an interview at the time of observation, the Maintenance Director agreed the fire alarm control panel had the wrong time and date. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)	K 0341	E 341 It is the expectation of this facility that all equipment in this facility be tested as required, functioning as intended, and up to date by state and federal guidelines. *The corrective action taken for those resident found to be affected by the deficient practice include:* No residents were affected by this alleged violation. Time and date stamp on the fire panel does not affect it's operation or readiness. *Other residents have the potential to be affected have been identified by:* This particular violation does not affect residents. *The measures of systemic changes that have been put in place to ensure that the deficient practice does not recur include:* The time and date were made current the day it was identified by the surveyor. We have added a check of the date and time on the fire drill form so the panel is always current and accurate. *The corrective action taken to monitor the performance to assure compliance through quality assurance is:* Maintenance Director will check that panel each drill and mark it on his sheet. Those results will be added to the monthly Quality Assurance Performance Improvement meeting for six	03/01/2024

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			months to ensure accuracy of equipment. Any issue that arises from the generator will be reported and fixed immediately. *The date the systemic change will be completed: 3/1/2024*	
K 0363 SS=E 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 sprinklered. Fixed fire window assemblies are			

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	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 only hold open devices that release when the door is pushed or pulled was used for 1 of 1 therapy doors. This deficient practice could affect 5 residents that use the therapy gym. Findings include: Based on observation with the Maintenance Director on 02/29/24 at 11:13 a.m., the therapy gym corridor door was held open with a door kick stop on the front of the door, and the door would not close by just pulling or pushing the door. Based on interview at the time of observation, the Maintenance Director agreed a kick stop was holding the door open and could not close the door unless the stop was kicked up first. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)	K 0363	It is the practice of this facility to ensure that all doors are complete and meet required fire ratings and do not have any hindrance to their operation. *The corrective action taken for those residents found to be affected by the deficient practice include:* Residents who are in the therapy room have the potential to be affected. *Other residents that have the potential to be affected have been identified by:* Residents in the therapy room 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:* Mechanical door jam removed from therapy room. *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	03/01/2024

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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 and that none have anything holding them open that would impede them closing from the outside. Those results will be submitted to the Senior 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: 3/1/2024*	
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 1 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	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:*	03/13/2024

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	all staff and residents. Findings include: Based on records review with the Maintenance Director on 02/29/24 at 10:02 a.m., no documentation was available to show a third shift fire drill for the second quarter of 2023 was conducted. Based on an interview at the time of record review, the Maintenance Director stated the aforementioned drill was not conducted. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b) 3.1-51(c)		No residents were affected by this deficiency. One third shift fire drill was found not to have been completed on time eight months ago. *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:* Fire Drills have been completed as required before and after this one missed instance. 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: 3/13/2024*	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5,			

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	Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen trans-filling rooms were separated from other areas in the facility in a room that is protected with a one-hour fire-resistive construction in accordance with 2012 NFPA 99 11.5.2.3.1(1). This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director on 02/29/24 at 12:04 p.m., the oxygen trans-filling room was not protected with a one-hour fire-resistive construction due to a two by three-foot hole in the wall and a three-inch by five-foot channel cut in the wall. Based on an interview at the time of observation, the Maintenance Director agreed there were large cutouts in the wall of the oxygen trans-filling room. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)	K 0927	K 927 It is the practice of this facility that the walls of the oxygen room be maintained and without damage. *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 this deficiency. *The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include:* Cut out area in the oxygen room was replaced and sealed to maintain integrity of wall for the complete room. *The corrective action taken to monitor the performance to assure compliance through quality assurance is:* The Maintenance Director is responsible for maintaining the	03/13/2024

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			integrity of fire walls and doors and the condition of the oxygen room. The Oxygen Room walls have been added to his daily walkthrough and submitted to the Senior Administrator weekly. Those results will be 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: 3/13/2024*	