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	01/27/2025

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: January 21, 22, 23, 24, and 27, 2025 Facility number: 000529 Provider number: 155482 AIM number: 100267140 Census Bed Type: SNF/NF: 50 Total: 50 Census Payor Type: Medicare: 1 Medicaid: 41 Other: 8 Total: 50 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 30, 2025	F 0000	Please accept this Plan Of Correction as proof of compliance for all citations related to this annual survey. We respectfully request a bench review/paper compliance outcome.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview, and record review the facility failed to ensure oxygen orders were obtained and implemented for 1 of 3 residents reviewed (Resident 47). Findings include: During an observation, on 1/21/25 at 11:02 AM,	F 0695	F695 It is the practice of this facility to ensure that residents who require oxygen have a physicians order for oxygen which contains the flow rate and it is being administered at the ordered rate. · What corrective action will be accomplished for those residents	02/13/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Anthony L Hill	Senior Administrator	02/07/2025

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	Resident 47 was observed lying in bed wearing a nasal cannula attached to an oxygen concentrator running at 1.75 liters per minute (lpm). A piece of tape attached to the concentrator read 3.5 lpm. Resident 47's record was reviewed on 1/21/25 at 1:16 PM. Diagnoses included adult failure to thrive and personal history of pulmonary embolism. Resident 47's current quarterly Minimum Data Set (MDS), dated 12/18/25, indicated their Basic Interview for Mental Status (BIMS) score was 15 (cognitively intact). The MDS indicated Resident 47 used supplemental oxygen. Resident 47's current care plan titled alteration in respiratory status ... indicated the resident had a problem of difficulty breathing, with a goal date of 3/19/25. Interventions included providing oxygen as ordered. Physician orders, dated 12/23/24 ,indicated oxygen tubing and a respiratory bag should be changed weekly on Mondays, oxygen humidification water levels should be checked each shift and replaced as needed. No physician orders for oxygen administration and rate of flow were available for review. In an interview, on 1/21/25 at 11:26 AM, Licensed Practical Nurse (LPN) 2 indicated an oxygen flow rate is determined and ordered by the physician. LPN 2 indicated he reviewed the current physician's orders and was unable to find any current orders. He indicated the oxygen was currently running at 1.75 lpm and he did not know what the oxygen flow rate should be. In an interview, on 1/21/25 at 11:30 AM, the		found to have been affected by the deficient practice. A physician's order for oxygen including the flow rate was obtained for resident #47 and the setting adjusted on the concentrator. The sticker indicating the flow rate was corrected. · How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents who require oxygen have the potential to be affected by the alleged deficient practice. A review of each resident's medical record was completed to identify that orders were in place for residents who require oxygen and equipment was checked to ensure at the correct flow rate. · 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 "Oxygen Administration" was reviewed by the IDT. An in-service will be provided to the nursing staff on the policy to ensure that each resident requiring oxygen has a physician's order for the use of oxygen and it is received at the correct oxygen administration flow rate. A Quality Assurance tool has been developed to monitor oxygen orders and flow rates for those resident utilizing oxygen.	

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	Director of Nursing (DON) indicated Resident 47's oxygen order may not have carried over after a recent hospitalization. She indicated a physician's order for administration of oxygen and a flow rate should be present in the medical record for all residents receiving oxygen. In an interview, on 1/21/25 at 11:55 AM, the DON indicated she reviewed readmission orders from the hospital and Resident 47 should have been receiving oxygen at 1 lpm. A current policy dated October 2010, provided by the DON on 1/21/25 at 12:07 PM indicated staff should verify the physician's order before administering oxygen. 3.1-47(a)(6)		· How the corrective action 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 for residents on oxygen to ensure orders are in place and oxygen is being administered at the correct flow rate. The audit will be completed on 5 residents weekly for three weeks, then monthly for three months, then quarterly x three months. 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 quarterly. · by what date the systemic changes for each deficiency will be completed: 2/13/2025	
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On Based on interview and record review, the facility failed to ensure pharmacy recommendations were followed for 1 of 5 residents reviewed (Resident 1). Findings include: Resident 1's record was reviewed on 1/24/25 at 7:46 AM. Diagnoses included primary hypertension and diabetes.	F 0756	F756 · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #1: The order was transcribed for discontinuation of eye drops on 4/23/24 and the orders for discontinuing insulin sliding scale and reducing	02/13/2025

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	Resident 1's Annual Minimum Data Set, (MDS) dated 10/31/24, indicated the resident's Brief Interview for Mental Status (BIMS) score was 12 (cognitively intact). A physician order, dated 2/5/24, indicated Resident 1 was to be administered Maxitrol Ophthalmic Suspension (antibiotic eye drops) to each eye 4 times a day for eye inflammation. A pharmacy note, dated 2/29/24, indicated Resident 1's antibiotic eye drops should be stopped on 3/7/24. Resident 1's physician agreed the antibiotic eye drops should be stopped on 3/7/24. Resident 1's Medication Administration Record, (MAR) dated 3/1/24 through 3/31/24 indicated the resident had been administered antibiotic eye drops 4 times a day every day through 3/31/24. A pharmacy note, dated 4/22/24, indicated Resident 1's antibiotic eye drops were to be stopped on 3/7/24. The pharmacy note indicated the antibiotic eye drops should be discontinued. Resident 1's MAR, dated 4/1/24 through 4/30/24, indicated the resident had been administered the eye drops 4 times a day from 4/1/24 through 4/22/24. A pharmacy note, dated 10/22/24, indicated the pharmacist recommended discontinuing Resident 1's sliding scale insulin and decreasing Resident 1's blood sugar checks from 4 times a day to once a day. The physician agreed. Resident 1's MAR, dated 10/1/24 through 10/31/24, indicated the resident's orders for		frequency of BS checks was transcribed on 11/20/24. NP and family were notified with no adverse effects from the alleged deficient practice. · 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 with recommendations made on the monthly medication regimen review have the potential to be affected by the alleged deficient practice. The pharmacy recommendations from the previous year were reviewed with no other concerns 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 policy "Medication Regimen Review Monthly Report" was reviewed by the IDT. An in-service will be conducted by 2/13/25 with the licensed nursing staff to ensure that each resident with a new physician's order from the pharmacy drug regimen review is transcribed when received. A Quality Assurance tool has been developed to monitor that orders received on the pharmacy reviews have been processed. · How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	

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	reduction of blood sugar checks and sliding scale insulin had not been discontinued. The resident's blood sugar had been assessed 4 times a day every day from 10/1/24 through 10/31/24. The MAR indicated Resident 1 had been administered sliding scale insulin 22 times from 10/23/24 until 10/31/24. A pharmacy note, dated 11/19/24, indicated the pharmacist recommended Resident 1's sliding scale insulin be discontinued and their blood sugar checks decreased from 4 times a day to once daily. The physician agreed. Resident 1's MAR, dated 11/1/24-11/30/24, indicated Resident 1 had their blood sugar assessed 4 times a day from 11/1/24 until 11/20/24. The MAR indicated Resident 1 had been administered sliding scale insulin 19 times from 11/1/24 until 11/20/24. In an interview, on 1/24/25 at 3:00 PM, the Director of Nursing (DON) indicated they did not know the reason Resident 1's eye drops did not get discontinued as the pharmacist had recommended. The DON indicated Resident 1's sliding scale insulin should have been discontinued and blood sugar tests should have been decreased as recommended by the pharmacist on 10/22/24. In an interview, on 1/27/25 at 9:18 AM, the DON indicated Resident 1 had brought the antibiotic eye drops with them when they were admitted on 2/5/24. The DON indicated the eye drops did not have a stop date on the prescription bottle. The DON indicated the facility had ordered more eye drops on 3/7/24. The DON indicated Resident 1's daughter had reported the resident had been on the eye drops intermittently since the resident's		program will be put into place; The Quality Assurance Audit Tool will be completed by the Director of Nursing /Designee for residents with pharmacy recommendations to ensure any orders received have been transcribed. The audit will be completed on 5 residents weekly for three weeks, then monthly for three months, then quarterly x three months. 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 quarterly. · By what date the systemic changes for each deficiency will be completed: 2/13/2025	

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	eye surgery. The DON indicated the facility should have clarified the stop date for the eye drops. A current facility policy, titled "Guidelines for Notifying Physicians of Clinical Problems," dated 2005 and revised 2/2014, provided by the DON on 1/24/25 at 2:05 PM indicated the facility should notify the physician of significant medication errors immediately. The policy indicated the physician should be notified of medication errors that did not affect the resident's condition during the next routine communication with the physician. 3.1-25(h) 3.1-25(i)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation, interview and record review, the facility failed to ensure a comfortable environment was maintained for residents in 4 of 7 resident rooms observed. During an observation on 01/21/25 at 10:04 AM, in room 210, the wall nearest the bed headboard had missing paint and exposed drywall in vertical marks too many to count approximately 3 feet from the floor, in 3 feet wide by 12 inches to less than 1 inch in length. The opposite wall had scrape marks 12 inches from the floor and approximately 5 feet wide. The exterior bathroom wall was missing 12 inches of cove base trim. The interior bathroom wall was missing 4 inches of cove base trim. During an observation on 1/21/25 at 10:29 AM, in the bathroom of room 212, the floor had black	F 0921	F921 Safe/Functional/Sanitary/Comfortable Environment It is the practice of this facility to provide a safe and comfortable environment for residents and staff. Corrective Actions for those residents that were found to have been affected by this deficiency: Repairs outlined in 2567 as needing required in rooms 209, 210, 212, and 213 are complete. Ceiling on 200 hall identified to have been cracked has been repaired. How other residents having the potential to be affected by the same deficient practice will be	02/13/2025

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	specks at the square tile seams and a heavier distribution in the corners of tiles. The interior bathroom wall had missing paint and drywall down to the wire mesh measuring approximately 4 inches x 1.5 inches. 1 of 5 light bulbs over the mirror were not functioning. Caulk was missing between the counter and the vertical trim to both sides of the counter. In an interview on 1/22/25 at 2:25 PM, LPN 3 indicated she would report bed, oxygen, or equipment malfunction to maintenance using verbal communication or written work order. During an interview on 1/22/25 from 2:30-2:40 PM, the Maintenance Director indicated no knowledge of the missing cove base pieces nor problems with the walls in rooms 209-217. He indicated replacing cove bases would be quick and there would be no need to vacate a resident from a room. He also indicated that The Administrator and Director of Nursing (DON) try to plan for vacant room maintenance, but this had been difficult. In a continuous interview and observation on 1/24/25 at 09:50-10:05, Housekeeper 9 indicated the black substance on the bathroom floor of room 212 was likely wax build up or glue from underneath the tile and may be removed with scrapping. Housekeeper 9 indicated there were stains on the tile floor unable to be removed. Housekeeper 9 indicated wall damage such as cracks or holes, water leaks, or lights not working would be reported with a written work order. Housekeeper 9 indicated resident beds have caused damage to the walls. During an observation on 1/24/25 at 10:00 AM, the 200s hall wall had a thin crack approximately 3 feet long from the ceiling.		identified and what corrective actions will be taken: All residents have the potential to be affected. A complete audit of all resident rooms was completed with a checklist of repairs needed outlined by room. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: All staff were trained in work order policy. Housekeeping staff were trained on their cart checklists that include identifying damage and reporting it to maintenance officially in writing as it is noticed. An audit form was created that will be used to identify new damage and monitor progress on addressing already identified areas. How the corrective actions will be monitored to ensure the deficient practice does not recur: A performance improvement tool has been initiated for both maintenance and housekeeping. There will be five (5) rooms audited weekly for four weeks, then every other week for three months, then monthly an additional two months. Results of these audits will be shared at monthly Quality Improvement Meeting. Negative results will extend the review period until 100% compliance with reporting and timely repair is accomplished.	

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	During an observation on 1/27/25 at 11:01 AM, room 209 had an exterior bathroom wall with a section of scrapped paint approximately 2 feet x 3 inches approximately 9-12 inches from the floor. During an observation on 01/27/25 at 11:03 AM, room 213 had missing paint and white primer approximately 4 inches x 0.5 inch at approximately 5 feet from the floor. In an interview, on 01/27/25 at 09:31 AM the DON indicated, residents need to be vacated from a room for larger repairs. The DON indicated, the facility replaced a bed that damaged the wall. The DON indicated, the facility has one maintenance employee. In an interview, on 1/27/25 at 10:30 AM, the Maintenance Director indicated the Administrator, would review work orders entered into the TELS program (TELS is a building management platform designed for Asset Management, Life Safety, and Maintenance solutions). A regional consultant for maintenance within the cooperation would also be able to see work orders. The Maintenance Director indicated he had a repair list for every room except 2 rooms completed since he started in August, 2024. The Maintenance Director indicated the facility had been approved to get new flooring in 3 residents' rooms. The Maintenance Director was unable to produce repair list or list of work orders for review. A current policy received on 01/27/25 at 09:36 AM titled "Maintenance/Environmental Policy and Procedures," from the Maintenance Director, indicated all room shall be maintained in a clean and good order without defect or damage that effects usability and provide a homelike environment for the residents. For minor touch		By what date the systemic changes will be made: 2/13/2025	

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	ups to scrapes and damaged paint in occupied rooms, every effort will be made to conduct minor repairs without inconvenience or displacement to the resident. All maintenance issues must have a work order entered in the TELS program. A monthly audit will be conducted by maintenance to identify any areas that need attention. The areas that need attention will be added to a project list to address in a timely manner. (Not to exceed 30 days.) When a room becomes vacant, an assessment will be conducted (room turn) to determine any necessary repairs. A current policy, received on 1/22/25 at 3:30 PM, from the Maintenance Director, titled "Work Order Policy" dated 9/1/2022, indicated all work order be either written on the log in front of the maintenance office or entered into TELS program. Work orders that are properly entered into the system will be acted upon within 72 hours and reviewed by The Administrator daily through the TELS logs. "Telling the maintenance director or anyone else on the floor something is broken will not get it fixed. It MUST be in writing and include the exact location of the problem and the date of that finding." 3.1-19(e)			