| 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 | 02/26/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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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 |
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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 02/26/25<br><br>Facility Number: 000529<br>Provider Number: 155482<br>AIM Number: 100267140<br><br>At this Emergency Preparedness survey, Kendallville Manor was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73<br><br>The facility has 60 certified beds. At the time of the survey, the census was 46.<br><br>Quality Review completed on 02/28/25 | 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 6, 2025. We respectfully request paper compliance for this survey resolution. Before and after pictures and documentation of an actual emergency are included. | |
| E 0039<br>SS=F<br>Bldg. -- | 403.748(d)(2), 416.54(d)(2), 418.113(d)(<br>EP Testing Requirements<br><br>Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.<br>b. If the LTC facility experiences an actual natural or man-made emergency that requires activation | E 0039 | E 039<br>It is the policy of this facility that EP testing requirements be completed annually as outlined in the regulation.<br>*The corrective action taken for those residents found to be affected by the deficient practice include:*<br>All residents could be affected by the potential of an emergency the staff are not properly trained to react to. | 03/06/2025 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Anthony L Hill | Senior Administrator | 03/06/2025 |

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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| | of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event.<br>(ii) Conduct an additional exercise that may include, but is not limited to the following:<br>a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise.<br>b. A mock disaster drill; or<br>c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on records review with the Maintenance Director and the Administrator on 02/26/25 at 10:12 a.m., there was documentation for a tabletop exercise conducted on 12/07/24, but no documentation of an annual community-based full-scale exercise, an annual individual facility-based functional exercise when a community-based exercise is not accessible, or an actual natural or man-made emergency was not available for review. Based on an interview at the time of records review, the Administrator stated a community-based, facility based, or an actual emergency were not completed within the last year. | | *Other residents have the potential to be affected have been identified by:*<br>All residents have the potential to be affected.<br>*The measures of systemic changes that have been put in place to ensure that the deficient practice does not recur include:*<br>The facility experienced flooding in several areas throughout the facility on 2/28/25-3/1/25 in which emergency procedures had to be utilized. Training was provided to all staff for their responsible areas. Emergency management procedures were enacted including contacting the fire department and SafeCare due to having to shut off the water including the sprinkler system. Documentation of our actions, the fire watch, and the training including all signatures is attached.<br>*The corrective action taken to monitor the performance to assure compliance through quality assurance is:*<br>Annual full scale emergency training including an exercise has been edited in TELS to include “if no community exercise has been completed by the county authorities by 12/1 of each year the facility will initiate their own with all proper authorities notified and all staff participating”.<br>*The date the systemic change will be completed: 3/6/2025* | |

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| | This finding was reviewed with the Maintenance Director and the Administrator during the exit conference. | | | |
| K 0000<br><br>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).<br><br>Survey Date: 02/26/25<br><br>Facility Number: 000529<br>Provider Number: 155482<br>AIM Number: 100267140<br><br>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.<br><br>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 is partly protected by a type II ESS propane generator. The facility has a capacity of 60 and had a census of 46 at the time of this survey.<br><br>All areas where the residents have customary access are sprinklered. The facility does have a | 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 6, 2025. We respectfully request paper compliance for this survey resolution. Before and after pictures and documentation of an actual emergency are included. | |

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| | barn and a shed providing facility services that were not sprinklered<br><br>Quality Review completed on 02/28/25 | | | |
| K 0324 SS=C Bldg. 01 | NFPA 101<br>Cooking Facilities<br><br>Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to the designed and installed positions for 1 of 1 kitchen hood extinguishing system. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2, states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 states the fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 states an approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice affects staff in the kitchen and 30 residents in the main dining room.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director on 02/26/25 at 12:01 p.m., the cooking | K 0324 | K 324<br>It is the practice of this facility that federal and state guidelines be met in all contexts.<br>*The corrective action taken for those resident found to be affected by the deficient practice include:*<br>All residents could be affected by the potential of a failure of the cooking hood due to placement of the stove creating a potential fire.<br>*Other residents have the potential to be affected have been identified by:*<br>All residents have the potential to be affected.<br>*The measures of systemic changes that have been put in place to ensure that the deficient practice does not recur include:*<br>The stove was moved by SafeCare back to it's original positioning and marked on the floor so that it is always placed correctly if moved for any reason. Please see attached pictures.<br>*The corrective action taken to monitor the performance to assure compliance through quality assurance is:*<br>Positioning of the stove has been | 03/06/2025 |

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| | equipment in the main kitchen was covered by the fire suppression system, but the kitchen was not provided with an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning. Based on an interview during observation, the Maintenance Director agreed the kitchen was not provided with an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning.<br><br>This finding was reviewed with the Maintenance Director and the Administrator during the exit conference.<br><br>3.1-19(b) | | added to the monthly kitchen review and will be audited by the administrator monthly as part of the general checklist. Those results will be shared with the IDT during monthly QAPI meetings if any variance is noted. This will be an on-going audit with no stop date.<br>*The date the systemic change will be completed: 3/6/2025* | |
| K 0374 SS=E Bldg. 01 | NFPA 101<br>Subdivision of Building Spaces - Smoke Barrie<br>Based on observation, records review, and interview, the facility failed to ensure 1 of 3 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. NFPA 101 2012 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect 25 residents in two smoke compartments<br><br>Finding include:<br><br>Based on observation with the Maintenance Director on 02/26/25 at 11:20 a.m., the smoke barrier wall to the dining room had a one-inch gap between the smoke doors when closed due to the | K 0374 | K 374<br>It is the policy of this facility that smoke barriers be in tact and functioning and meet the guidelines of the federal and state regulations.<br>*The corrective action taken for those residents found to be affected by the deficient practice include:*<br>All residents could be affected by a smoke barrier not having the proper integrity.<br>*Other residents have the potential to be affected have been identified by:*<br>All residents have the potential to be affected. | 03/06/2025 |

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| | astragal being removed. Based on records review at 11:30 p.m., the facility building plans indicated the wall entering the dining room was a one-hour smoke barrier wall. Based on an interview at the time of observation and at the time of records review, the Maintenance Director stated the astragal was removed due to damage, the doors to the dining room were in a smoke barrier wall, and agreed there was a gap larger than 1/8 inch between the smoke doors when closed.<br><br>This finding was reviewed with the Maintenance Director and the Administrator during the exit conference.<br><br>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:*<br>An aluminum strip was screwed into the door that covers the gap noted during survey. In addition the astragal was put back into it's original position and the door functions as required.<br>*The corrective action taken to monitor the performance to assure compliance through quality assurance is:*<br>Smoke barrier door assessments are done weekly per TELS. The Maintenance Director will provide the results of that audit to the IDT monthly as part of QAPI and include it in our monthly Safety Committee documentation. In variance or damage will be repaired immediately and proof of that repair will be included in the Safety Committee documentation. This is an on-going audit with no stop date.<br>*The date the systemic change will be completed: 3/6/2025* | |