Printed: 10/31/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kendallville Manor	1802 E Dowling St Kendallville, IN 46755

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45794

Based on interview and record review the facility failed to ensure residents were free from abuse for 2 of 6 residents reviewed (Resident A and Resident B).

Findings include:

A report to the Indiana Department of Health dated 8/6/24 indicated there was a concern about residents being abused by a staff member.

1. Resident A's record was reviewed on 8/27/24 at 10:00 AM. Diagnoses included cerebral palsy, aphasia, (inability to speak) major depressive disorder, anxiety disorder and mood disorder.

Resident A's Quarterly Minimum Data Set, (MDS) dated [DATE], indicated the resident's Brief Interview for Mental Status (BIMS) score was 8 (moderate cognitive impairment). The MDS indicated Resident A required extensive assistance for activities of daily living (ADLs). The MDS indicated Resident A had a suprapubic indwelling urinary catheter and a feeding tube.

A progress note date 8/5/24 at 9:10 PM indicated a staff member had made physical contact with the resident's right arm.

A Trauma Evaluation, dated 8/6/24 at 8:53 AM, indicated Resident A had stuck their arm out in front of Certified Nurse Aide (CNA) 10 as CNA 10 was walking by. The progress note indicated CNA 10 flung Resident A's arm out of their way. The progress note indicated Resident A had been known to place their arm in front of other residents and staff members to gain their attention due to Resident A being nonverbal.

An undated, written statement by CNA 10, indicated CNA 10 had pushed Resident A's hand down to pass by the resident to answer a call light.

A written statement by CNA 30, dated 8/5/24, indicated they witnessed CNA 10 push Resident B's arm away.

(continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/27/24 at 1:17 pm, CNA 10 indicated they had worked a stressful shift at the facility on 8/5/24. CNA 10 indicated the shift was stressful due to unproductive staff members and numerous residents with mental health disorders. CNA 10 indicated they did not abuse residents. CNA 10 indicated they did not hit Resident A. CNA 10 indicated they pushed Resident A's hand out of the way to pass by. 2. Resident B's record was reviewed on 8/27/24 at 10:45 AM. Resident B's diagnoses included cognitive communication deficit, unspecified mild dementia, major depressive disorder, anxiety disorder and behavioral disorders. Resident B had resided at a homeless shelter prior to admission to the facility. Resident B's Quarterly MDS, date 6/19/24, indicated the resident's BIMS score was 15 (cognitively intact). The MDS indicated Resident B required minimal assistance for ADLs. A Nursing Note, dated 8/6/24 at 9:17 AM, indicated on 8/5/24 CNA 10 had been attempting to enter Resident B's room to provide care for their roommate. Resident B had told CNA 10 they were not permitted to enter their room, slammed the door and held the door shut. CNA 10 then pushed the door open forcefully. A Trauma Evaluation, dated 8/6/24 at 10:28 AM, indicated Resident B had closed and held their room door shut to prevent CNA 10 from entering the room to care for their roommate. CNA 10 had pushed on the door while Resident B was holding the door shut. An identified trigger was Resident B's resistance to interacting with others they perceived as having lower function. Resident B indicated they became upset with others when others were stupid. A Behavior Note, dated 8/9/24 at 2:18 PM, indicated Resident B had displayed unkind behaviors to others as evidenced by sticking their tongue out, yelling, using profane language and raising their middle finger. Resident B had been angry with a staff member, refused a rational explanation and had refused alternate accommodations. In an interview on 8/27/24 at 12:05 PM, Resident B indicated they did not feel like talking. Resident B reported they were angry with another resident who didn't know anything. A written statement by CNA 20, dated 8/5/24, indicated CNA 10 had engaged in a verbally abusive conservation with Resident B. Resident B held their room door closed. CNA 10 then placed both hands on the door and pushed with excessive force. CNA 20 prevented the door from striking Resident B. In an interview on 8/27/24 at 1:17 pm CNA 10 indicated on 8/5/24 Resident B had an attitude all day. CNA 10 indicated Resident B was abusive when slamming the door in CNA 10's face. CNA 10 indicated they could have handled themselves better. CNA 10 indicated they regretted using foul language. In an interview on 8/27/24 at 11:45 AM, Licensed Practical Nurse (LPN) 40 indicated CNA 10 could be impatient with the residents. In an interview on 8/27/24 at 12:29 PM, Resident C indicated CNA 10 was scary when they were mad. Resident C indicated CNA 10 displayed negative body language when they were angry. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/27/24 at 12:39 PM, the Director of Nursing (DON) indicated they were aware of the abuse allegations being supported by evidence. A current facility policy, dated 9/2022, provided by the DON on 8/27/24 at 10:40 AM indicated residents should not be abused by other residents, volunteers, family members, legal guardians, friends or facility staff. This citation relates to Complaint IN00440431. 3.1-27(a)