

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155851	X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: _____	X3) DATE SURVEY COMPLETED  02/11/2025
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NAME OF PROVIDER OR SUPPLIER  ORCHARD POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP COD 702 SAWYER ROAD 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: 02/11/25  Facility Number: 013704 Provider Number: 155851 AIM Number: 300017679  At this Emergency Preparedness survey, Orchard Pointe Health Campus was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.  The facility has 58 certified beds. At the time of the survey, the census was 50.  Quality Review completed on 02/12/25	E 0000	The preparation and execution of this Plan of Correction do not constitute an admission or agreement by the provider regarding the truth of the facts or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and executed solely to comply with Federal and State law. It responds to the allegations of noncompliance cited during the Annual Recertification and State Licensure Survey on February 11, 2025. Please accept this Plan of Correction as Orchard Pointe's credible allegation of compliance, effective February 28, 2025. The provider respectfully requests a desktop review for the health campus with paper compliance to establish substantial compliance.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements  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: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.	E 0039	1.A campus tabletop exercise was completed with all leadership team members on February 21, 2025. A facility-based drill was conducted at the campus on February 25, 2025, due to a community-based drill scheduled with the Noble County Fire Department for April 17, 2025. 2.Home Office Facility Maintenance Support provided	02/28/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Haylee Everidge	Executive Director	02/26/2025

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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	<p>b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise that may include, but is not limited to the following:</p> <p>a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise.</p> <p>b. A mock disaster drill; or</p> <p>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.</p> <p>(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).</p> <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review and interview with the Director of Plant Operations from 9:15 a.m. to 11:32 a.m. on 02/11/25, the facility failed to provide documentation of any exercises to test the emergency preparedness plan. Based on interview at the time of record review, the Director of Plant Operations was not aware of any exercises that were conducted in the last year.</p> <p>This finding was reviewed with an Administrator</p>		<p>education to the ED and DPO regarding EP Testing Requirements. A new Disaster Drills Binder has been implemented at the campus for all EP-specific testing and drills.</p> <p>3.To ensure ongoing compliance, an annual task has been added to the TELS system for sign-off and completion by the DPO.</p> <p>4.As a quality measure, the DPO or designee will review any findings and corrective actions monthly at QAPI for 6 months.</p> <p>5.This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements, with a compliance date of February 28, 2025.</p>	

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K 0000  Bldg. 01	<p>and Director of Plant Operations at the exit conference.</p> <p>A Life Safety Code Certification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 02/11/25</p> <p>Facility Number: 013704 Provider Number: 155851 AIM Number: 300017679</p> <p>At this Life Safety Code survey, Orchard Pointe Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, the 2012 edition of NFPA (National Fire Protection Association) 101, LSC (Life Safety Code). The facility was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one-story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in resident rooms, in corridors and in spaces open to the corridors. The building is partially protected by a 150-kW natural gas powered emergency generator. The facility has 58 certified beds. The facility had a census of 50 at the time of this survey.</p> <p>All areas where residents have customary access and all areas providing facility services were sprinklered.</p>	K 0000	The preparation and execution of this Plan of Correction do not constitute an admission or agreement by the provider regarding the truth of the facts or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and executed solely to comply with Federal and State law. It responds to the allegations of noncompliance cited during the Annual Recertification and State Licensure Survey on February 11, 2025. Please accept this Plan of Correction as Orchard Pointe's credible allegation of compliance, effective February 28, 2025. The provider respectfully requests a desktop review for the health campus with paper compliance to establish substantial compliance.	

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K 0712 SS=F Bldg. 01	<p>Quality Review completed on 02/12/25</p> <p>NFPA 101 Fire Drills</p> <p>Based on record review and interview, the facility failed to conduct 3 of 12 fire drills in 3 of 4 quarters during the most recent twelve month time period. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents.</p> <p>Findings include:</p> <p>Based on record review and interview with the Director of Plant Operations from 9:15 a.m. to 11:32 a.m. on 02/11/25, the facility was unable to provide documentation of a fire drill for the first shift in the first quarter of 2024; third shift in the third quarter of 2024 or a second shift in the fourth quarter of 2024. Based on interview at the time of record review, the Director of Plant Operations acknowledged the missing fire drill documentation stating that he had recently started working at the facility.</p> <p>3.1-19(b) 3.1-51(c)</p>	K 0712	<p>1.This alleged deficient practice could have affected all residents. A new DPO has been in place since December 31, 2024, with updated TELS reporting.</p> <p>2.Home Office Facility Maintenance Support provided education to the ED and DPO on fire drills.</p> <p>3.Compliance tasks are listed within the TELS system to ensure monthly sign-off for ongoing compliance.</p> <p>4.As a quality measure, the DPO or designee will review any findings and corrective actions monthly at QAPI for 6 months and present completed drills for review during QAPI meetings for 6 months.</p> <p>5.This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements, with a compliance date of February 28, 2025.</p>	02/28/2025
K 0920 SS=D Bldg. 01	<p>NFPA 101 Electrical Equipment - Power Cords and Extens</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8</p>	K 0920	<p>1.The resident experienced no adverse effects from the alleged practice. The power strip was immediately removed from the resident's room.</p> <p>2.Home Office Facility</p>	02/28/2025

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K 0923 SS=F Bldg. 01	<p>requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects one resident only.</p> <p>Findings include:</p> <p>Based on observation and interview with the Director of Plant Operations from 11:34 a.m. to 1:17 p.m. on 02/11/25, a power strip was found powering a refrigerator in resident room 106 on the 100 hall. Based on interview at the time of each observation, the Director of Plant Operations acknowledged power strip was powering a refrigerator and stated he was aware that the refrigerator needed to be plugged directly into the wall.</p> <p>3.1-19(b)</p> <p>NFPA 101 Gas Equipment - Cylinder and Container Storag</p> <p>Based on observation and interview, the facility failed to ensure 13 of 13 full and empty oxygen cylinders were separated and marked to avoid confusion. This deficient practice could affect all residents and staff.</p> <p>Findings include:</p> <p>Based on observation and interview with the Director of Plant Operations from 11:34 a.m. to 1:17 p.m. on 02/11/25, the oxygen storage room</p>	K 0923	<p>Maintenance Support provided education to the Executive Director (ED) and Director of Plant Operations (DPO) regarding power strip usage.</p> <p>3.To ensure ongoing compliance, random audits of resident rooms will be conducted to verify that resident refrigerators are plugged directly into the wall. This will occur twice weekly for 4 weeks, once weekly for 8 weeks, and every other week for an additional 8 weeks.</p> <p>4.As a quality measure, the DPO or designee will review any findings and corrective actions monthly at the Quality Assurance and Performance Improvement (QAPI) meetings for 6 months.</p> <p>5.This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements, with a compliance date of February 28, 2025.</p> <p>1.An Oxygen Company representative visited Orchard Pointe Health Campus on February 18, 2025, to ensure appropriate signage was placed in the oxygen room, marking cylinders as "full" or "empty."</p> <p>2.Home Office Facility Maintenance Support provided education to the ED and DPO regarding cylinder and container</p>	02/28/2025	

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	<p>contained full and empty oxygen cylinders, but the cylinders were mixed together and not marked as full or empty. Based on interview at the time of observation, the Maintenance Director acknowledged the cylinders were separated and not marked as full and empty.</p> <p>This finding was reviewed with an Administrator and Director of Plant Operations at the exit conference.</p> <p>3.1-19(b)</p>		<p>storage.</p> <p>3.To ensure ongoing compliance, random audits of the oxygen room for proper signage will be conducted twice weekly for 4 weeks, once weekly for 8 weeks, and every other week for an additional 8 weeks.</p> <p>4.As a quality measure, the DPO or designee will review any findings and corrective actions monthly at QAPI for 6 months.</p> <p>5.This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements, with a compliance date of February 28, 2025.</p>		