

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012396	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/05/2014
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NAME OF PROVIDER OR SUPPLIER RITTENHOUSE SENIOR LIVING OF PORTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6235 STERLING CREEK RD PORTAGE, IN 46368
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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) COMPLETE DATE
{R 000}	<p>INITIAL COMMENTS</p> <p>This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaint IN00144502 completed on March 18, 2014.</p> <p>Complaint IN00144502- Corrected</p> <p>Survey date: May 5, 2014</p> <p>Facility number: 012396 Provider number: 012396 AIM Number: N/A</p> <p>Survey team: Janet Adams, RN-TC</p> <p>Census bed type: Residential: 89 Total: 89</p> <p>Census payor type: Other: 89 Total: 89</p> <p>Sample: 3</p> <p>Rittenhouse Senior Living of Portage was found to be in compliance with 410 IAC 16.2 in regard to the PSR to the Investigation of Complaint IN00144502.</p> <p>Quality review completed on May 8, 2014, by Janelyn Kulik, RN.</p>	{R 000}		

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