STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF PORTAGE	6235 STERLING CREEK RD PORTAGE, IN 46368

(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) COMPLETION DATE
R000000	This visit was for the Investigation of Complaints IN00118331 and IN00120634. Complaint IN00118331-Substantiated. State residential findings related to the allegations are cited at R 0036 and R 0407. Complaint IN00120634-Substantiated. State residential findings related to the allegations are cited at R 0036 and R 0407. Unrelated findings cited. Survey date: March 15, 2013 Facility number: 012396 Provider number: 012396 AIM number: N/A Survey team: Janet Adams, RN, TC Janelyn Kulik, RN Census bed type: Residential: 66 Total: 66 Census payor type: Other: 66 Total: 66	R000000	The following is the Plan of Correction for the Rittenhouse Senior Living of Portage in regards to the Statement of Deficiencies dated March 15, 2013. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF PORTAGE	6235 STERLING CREEK RD PORTAGE, IN 46368

(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) COMPLETION DATE
	Sample: 13 These state residential findings are cited in accordance with 410 IAC 16.2. Quality review completed on March 21, 2013, by Janelyn Kulik.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF PORTAGE	6235 STERLING CREEK RD PORTAGE, IN 46368

(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) COMPLETION DATE
R000036	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to ensure the Physician was notified of the development of a skin condition in a timely manner and status of the skin condition after receiving the ordered treatment for 1 of 10 residents reviewed for skin conditions in the sample of 13. (Resident #E) Findings include: The record for Resident #E was reviewed on 3/15/13 at 11:10 a.m. The resident's diagnoses included, but were not limited to, dementia, Alzheimer's disease, high blood pressure, dermatitis, and resolved scabies. Review of the 10/2012 Physician orders indicated an order was written on 10/11/12 to apply Trimincolone	R000036	The following corrective actions have been taken: 1. Resident #E's physician was originally contacted on 09/27/2012 and order was given for Triamcinole Cream on 10/11/2012 prn. Order was clarified on 10/15/2012 to Triamcinole Cream BID. Resident #E was then seen on 10/26/2012 by physician who noted rash improved and Dx Dermatitis. 11/2/2012 new orders for rash were received from physician. 11/07/2012 Resident #E returned to facility with daughter with new orders from urgent care physician for rash on face and trunk. Dr saw resident on 11/08/2012 and Dx pruritic rash to back and chest. Discontinued Triamcinolone cream and started Bactroban.11/21/2012 physician updated on increase to rash. 11/26/2012 Resident #E saw Dermatologist and was Dx Scabies. New order for eliminte cream was received. 11/29/2012 physician was in and	04/15/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF PORTAGE	6235 STERLING CREEK RD PORTAGE, IN 46368

(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) COMPLETION DATE
	0.1% cream to the reddened areas twice a day prn (as needed). Another Physician's order was written on 10/15/12 to apply Trimincolone 0.1% cream to the reddened area on the skin twice a day for 10 days. Review of the 10/2012 Treatment Record indicated the Trimincolone 0.1% cream prn was signed out one time. The cream was signed out on 10/13/12. The Trimincolone 0.1% cream to be applied twice a day for 10 days was signed out 10/15/12 through 10/26/12. The 11/29/12 Physician Progress Note was reviewed. The Progress Note indicated the resident was diagnosed with scabies and orders were to treat the area with Permethrin. Review of the 9/2012 Resident Notes indicated an entry was made on 9/27/12 at 12:30 p.m. This entry indicated a red pinpoint rash was observed on the resident's left side with itching. The entry indicated the Physician was called. An entry made on 9/28/12 at 5:15 a.m. indicated the rash remained to the resident's left side and the resident denied itching. An entry made on 9/29/12 at 12:00 a.m.		noted improved rash. 12/10/2012 follow up with Dermatologist and tested negative for scabies. 12/20/2012 physician saw resident and noted improved rash. 01/07/2013 Dermatology appointment follow up noted scabies resolved and much improved. 2. All resident charts were audited to ensure physician and family were notified. To ensure this practice does not recur and provide systemic changes: All residents have the potential to be affected by this practice. All nurses and QMA's were educated on 03/28/2013 regarding physician notification policy and how to document when follow up with a physician is needed. The Director of Nursing or designee will audit the nurses report binder for follow up daily Monday through Friday indefinitely. To monitor the effectiveness of these corrective actions: The ED or designee will monitor the audit reports at the weekly managers meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF PORTAGE	6235 STERLING CREEK RD PORTAGE, IN 46368

(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) COMPLETION DATE
	indicated the rash remained to the resident's left side and the Physician was faxed and staff were awaiting a response. Review of the 9/30/12 thru 10/5/12 Resident Notes indicated there was no documentation of a response from the Physician. An entry made on 10/6/12 at 5:40 a.m. indicated a red raised rash was noted to the resident's trunk, face, and legs and the resident was scratching. This entry also indicated the Physician was faxed. The next entry was made on 10/7/12 at 12:00 a.m. This entry indicated small raised rash was noted on the left side of the resident's stomach and the Physician was faxed on 10/6/12 for a treatment order. The next entry was made on 10/9/12 at 2:00 p.m. This entry indicated a rash was observed to the resident's trunk, back, and legs and the resident continued to scratch. The next entry was made on 10/11/12 at 10:00 a.m. This entry indicated a red, raised, pinpoint rash was observed on the resident's trunk, abdomen, and back of the upper arms and the Physician was faxed. There was no documentation of any other attempts to notify the Physician or of the Physician responding to the two faxes sent on 9/29/12 and 10/6/12 until 10/11/12 when the Physician was faxed for the third time and the first			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF PORTAGE	6235 STERLING CREEK RD PORTAGE, IN 46368

(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) COMPLETION DATE
	treatment order for the rash was obtained. The Resident Notes from 10/26/12 through 10/30/12 were reviewed. An entry made on 10/26/12 at 12:30 p.m. indicated a rash remained to the resident's chest, back, and back of his arms. Entries made on 10/27/12 at 11;15 a.m. and 9:38 p.m. indicated the rash remained to the resident's back. An entry made on 10/28/12 at 4:00 a.m. indicated the rash remained to the resident's abdomen and back. An entry made on 10/29/12 at 1:30 p.m. indicated red raised non draining spots remained to the resident's chest and back with approximately twenty spots noted. There was no documentation in any of the above entries indicating the Physician had been notified of the continued rash after the ordered treatment was completed on 10/25/12. The 11/2012 Resident Notes were reviewed. Entries made on 11/2/12 and 11/3/12 did not indicated any documentation of skin rashes. An entry made on 11/8/12 at 12:00 a.m. indicated a rash remained on the resident's face and trunk. The next entry was made on 11/8/12 at 12:00 p.m. This entry indicated the Physician was present and new			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF PORTAGE	6235 STERLING CREEK RD PORTAGE, IN 46368

(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) COMPLETION DATE
	orders were given for Bactroban cream to be applied to the area twice a day and to update the Physician in one week. Review of the Resident Notes from 11/8/12 through 11/25/12 indicated there was no documentation of the Physician being notified with an update of the rash as ordered on 11/8/12. An entry made on 11/26/12 at 11:00 a.m. indicated the resident's family took him to see a Physician at a Dermatology office and the resident was diagnosed with scabies. When interviewed on 3/15/13 at 5:00 p.m., the Memory Care manager indicated there was no specific Physician notification policy. The Memory Care Manger indicated the Physician can be faxed and staff were then to follow up if no responses. This state residential tag relates to Complaints IN00118331 and IN00120634.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF PORTAGE	6235 STERLING CREEK RD PORTAGE, IN 46368

(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) COMPLETION DATE
R000052	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, record review, and interview, the facility failed to ensure residents remained free from neglect related to not providing adequate supervision to prevent elopements for 2 of 5 residents on the secured unit reviewed for elopement attempts in the sample of 13. (Residents #E, #L and #N) (LPN #1) (CNA's #1, #2, and #3) Findings include. 1. During Orientation Tour on 3/15/13 at 10:00 a.m., Resident #E and Resident #L were observed in the Memory Care unit (secured unit). The Memory Care unit was a secured unit. The Memory Care supervisor indicated both the residents together exited one of the exit doors leading to the outside a few days ago. The left hall exit door was observed with the Memory Care supervisor. There was a yellow tape across the door. The supervisor indicated the staff in the	R000052	The following corrective actions were taken: 1. Director of Nursing immediately came to facilty on 03/11/2013 and changed the batteries in the pagers. She then ensured all pagers were functioning correctly and educated staff on site regarding pager function. 2. Pager log was put into place for nurse in charge to check pager function and sign off each shift that all pagers are in use and functioning properly. To ensure this practice does not recur and provide systemic changes: All memory care residents have the potential to be affected by this practice. All nurses and QMA's were educated on the pager log and elopement policy on 03/28/2013. The Director of Nursing or designee will audit the pager logs weekly indefinitely. To monitor the effectiveness of these corrective actions: The ED or designee will monitor the audit reports at the weekly managers meeting. * IDR requested to dispute the tag cited. 2567 explained this Rule was not met as evidenced by facility failing to	04/15/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF PORTAGE	6235 STERLING CREEK RD PORTAGE, IN 46368

(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) COMPLETION DATE
	secured unit have pagers that will go off when the door is opened by a resident and the pagers will show the resident's name. The supervisor indicated the exit door is locked but will open if it is pushed on for 15 seconds or more. On 3/15/13 at 1:20 p.m., the area outside of the left hall exit door on the Memory Care unit was observed with the Memory Care supervisor. The door exited to a side walk leading to a garage and a parking lot. Parked cars were observed in the parking lot. The side walk curved around to a fenced in patio area adjacent to the facility building. There was a gate that would open into the patio. Inside the patio there was an entrance into the facility. This area was not on the Memory Care unit. This entrance was locked. The Memory Care Supervisor indicated Residents #E and #L exited the left hall exit door on the Memory Unit and were observed by staff from the Assisted Living unit at this locked entrance and the staff unlocked the door and brought the resident's inside the facility and escorted them to the Memory Care unit. The record for Resident #E was reviewed on 3/15/13 at 11:10 a.m. The resident's diagnoses included,		provide adequate supervision to prevent elopement of 2 of 5 residents on secured unit. Facility had an occupancy of 20 residents on 03/11/2013 and staffing at the time of the elopement was 1 LPN, 2 C.N.A.'s and 1 orientating C.N.A. on the memory care unit. When the residents eloped, the system worked as follows: The door alarmed and released after being pushed on for 15 seconds. The door once opened and audible alarming sent a signal to the computer in the nurses station alerting staff and the computer then sends a signal to both the memory care pagers and the assisted living pagers that the door was opened. The memory care pagers had dead batteries at the time of the occurrence. The Director of Nursing, once alerted to this, came in and replaced the batteries. I feel that we should have been cited for violation of 410 IAC 16.2-5-1.5 Sanitation and safety standards that states the facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF PORTAGE	6235 STERLING CREEK RD PORTAGE, IN 46368

(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) COMPLETION DATE
	but were not limited to, dementia, Alzheimer's disease, dermatitis, and high blood pressure. Review of the 3/11/13 Resident Notes indicated and entry was made at 7:45 p.m. The entry indicated the writer (Nurse) was administering medications to another resident and the CNA called her to help her in that resident's room. The notes indicated Resident's #E and #L were standing close and then walked down the hallway. The left hall door alarm sounded. An orientating CNA noted the yellow tape across the exit was down and Resident #E was not in his room. The note then indicated a staff member from the Assisted Living side of the facility came to the Memory Care Unit with Resident #E and Resident #L and the Assisted Living staff stated their pagers had gone off. The Assisted Living staff members brought the residents inside the building from the Cafe doors. The record for Resident #L was reviewed on 3/15/13 at 11:40 a.m. The resident's diagnoses included, but were not limited to, senile dementia, agitation, anxiety, and insomnia. The resident was admitted to the facility on 1/21/13. Review of an undated Pre-Screening			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF PORTAGE	6235 STERLING CREEK RD PORTAGE, IN 46368

(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) COMPLETION DATE
	Questionnaire indicated the resident wandered and needed daytime monitoring. Review of the 1/2013 and 2/2013 Resident Notes indicated an entry was made on 1/23/13 at 4:00 a.m. This entry indicated the resident was exit seeking and opened the main unit door and was stopped by staff. An entry made on 2/22/13 at 12:30 a.m. indicated the resident was walking up and down the hall, pushing/attempting to open the unit door. The 3/2013 Resident Notes were reviewed. An entry made on 3/11/13 at 7:45 p.m. indicated the writer (Nurse) was administering medications to another resident and needed the assistance of the CNA's. The entry also indicated Residents #E and #L were walking down the left side hallway. The entry indicated an alarm went off and a CNA checked the exit door and the yellow tape was not on the door. The CNA then checked the door and checked outside. The entry also indicated the staff noted that Resident #L was not in the hallway and then staff from the Assisted Living unit came to the Memory Care unit with Residents #L and #E who were found outside of the building.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF PORTAGE	6235 STERLING CREEK RD PORTAGE, IN 46368

(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) COMPLETION DATE
	An "Investigation of Incident Form" was reviewed on 3/15/13 at 1:00 p.m. The form indicated an incident occurred on 3/11/13 at 7:45 p.m. The form indicated Residents #E and #L exited an exterior door. There were Communication Forms attached to the Investigation of Incident Form. The first Communication Form was completed by LPN #1. This form indicated the LPN was administering medications and needed the assistance of CNA #1 and then heard the alarm sounding and CNA #1 ran down the hall and noted the yellow tape on the exit door was down and thought Resident #N had removed the tape and opened the door. The form then indicated the CNA then noted Resident #E was not in his room. The form also indicated the facility Director of Nursing came into the facility and replaced the batteries on all the pagers. A second Communication Form was completed by CNA #3 (an orientating CNA). The form indicated the CNA was in the TV room around 7:45 p.m. with her trainer (CNA #1) and as she looked down the hall she observed Resident #N near the exit door with the yellow tape and ran down and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF PORTAGE	6235 STERLING CREEK RD PORTAGE, IN 46368

(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) COMPLETION DATE
	assisted Resident #N into her room while CNA #1 went to the door and fixed the yellow tape and turned off the alarm. The form indicated the CNA's started heading back down the hall and noticed that Resident #E's room door was cracked opened and CNA #1 entered the room and Resident #E was not in his room. The form also indicated the CNA's then realized it was not Resident #N who opened the door and CNA #1 then ran to check outside and CNA #3 then ran upstairs to check for the Resident and by the time she returned to the unit the staff from the Assisted Living unit had brought Residents #E and #L back to their unit indicating the residents were outside knocking on the dining room door. A third Communication Form was completed by CNA #1. The form indicated the CNA was in the TV room around 7:45 p.m. and she looked down the hall and saw Resident #N looking outside of the left hallway exit door and the yellow tape was off of the exit door and the CNA went down the hall to stop the alarm. The form indicated the CNA then noticed that Resident #E's room door was open and the resident was not in the room. The form indicated the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF PORTAGE	6235 STERLING CREEK RD PORTAGE, IN 46368

(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) COMPLETION DATE
	CNA then ran outside looking for the resident and then another staff notified her staff from the Assisted Living unit had brought Residents #E and #L back inside after they were observed then knocking on the kitchen door. When interviewed on 3/15/13 at 1:15 p.m., the Director of Nursing indicated she was called by staff on 3/11/13 when Residents #E and #L had exited the facility. The Director of Nursing indicated the facility pager system is set up for staff to carry the pagers and the pagers will alert them of call lights and when secured doors are opened. The Director of Nursing indicated there was one Nurse, two CNA's and one orientating CNA working on the Memory Care unit the evening of 3/11/13 and three of them were to have pagers. The Director of Nursing indicated when she came to the facility she interviewed staff and the staff identified that none of the three pagers were working at the start of their shift in the Memory Care unit. The Director of Nursing indicated she replaced the batteries when she arrived at the facility. The Director of Nursing indicated there was an indicator on the pagers to indicate if the battery was low. The Director of Nursing indicated the staff members			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF PORTAGE	6235 STERLING CREEK RD PORTAGE, IN 46368

(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) COMPLETION DATE
	are responsible to ensure they receive a pager at change of shift and ensure that the pager is working properly.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF PORTAGE	6235 STERLING CREEK RD PORTAGE, IN 46368

(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) COMPLETION DATE
R000241	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on on record review and interview the facility failed to ensure physician's orders were followed for 1 of 3 residents reviewed related to administering the incorrect medications to a resident. (Resident #K and QMA #1). Findings included: The record for Resident #K was reviewed on 3/15/13 at 11:04 a.m. Her diagnoses, included but were not limited to, dementia, hypertension, dermatitis, and high cholesterol. Review of the Physicians Order Statement for March 2013, indicated the resident was to receive the following medications: Lotrel 5/20 mg (milligrams) dly (daily) (medication used to treat high blood pressure), Omega III one twice a day (medication used to treat high cholesterol), Prilosec 10 mg dly (medication used to treat stomach reflex), Thera one dly (multi vitamin), and Vit C 500 mg dly. A Resident Note dated 3/11/13 with no time, indicated "Resident given wrong medication by QMA, medication was for different resident. Writer contacted family and informed them et. (and) left message for Dr. (doctor) to return call. A Resident Note dated 3/11/13 at 8:45 a.m., indicated the resident was sent to the ER	R000241	The following corrective action has been taken: 1. QMA #1 was re-educated on facility policy and procedure for medication administration and corrective action was issued. To ensure this practice does not recur and provide systemic changes: All residents have the potential to be affected by this practice. All nurses and QMA's were re-educated on 03/28/2013 regarding proper medication administration procedures. To monitor the effectiveness of these corrective actions: The Director of Nursing or designee will watch a nurse or QMA complete medication administration weekly until 4 continuous weeks of compliance have been met in regards to follow proper medication administration procedures. The Director of Nursing will then watch one medication administration monthly to ensure ongoing compliance. The results of these checks will be discussed at our weekly managers meeting.	04/15/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF PORTAGE	6235 STERLING CREEK RD PORTAGE, IN 46368

(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) COMPLETION DATE
	(emergency room) via ambulance. Family met resident there. At 9:45 a.m. the Doctor returned call and was informed of the medication that the resident was given. Writer also heard from the ER nurse related to the resident's condition. The resident continued to show no issues to the mistaken medication and will be returned to the facility. At 3:30 p.m. the report from the ER was that the resident had a reaction of emesis (vomiting) multiple times. The resident was also given Narcan to reverse the narcotic effects. Resident remained conscious and normal per self in the ER. She never lost consciousness per report. The resident was to be transported back to the facility per the daughter. Review of an Investigation of Incident From dated 3/11/13 was provided by the DON at 11:53 a.m. on 3/15/13, indicated the type of incident was a medication error. A new QMA was passing meds, pulled wrong medications and gave to the resident who has the same first name. LPN #1 was reported to by QMA that wrong meds were given. When the LPN spoke to both QMAs she found out QMA #1 pulled the wrong medications. The injury was nausea and vomiting. The resident was sent to the ER for evaluation and treatment. QMA #1 was released of her duties and will not return to the community. The Nurses and QMAs had inservices to review medication administration on 3/14/13. A Medication Discrepancy Report dated 3/11/13 at 8:00 a.m., indicated QMA was giving medications on the second floor cart to residents in the main dining room. QMA pointed out Resident #K and another resident with the same first name. Resident #K received the other resident's medications. After medications were administered the resident did not show any signs or symptoms of hypersensitivity to the narcotic medication.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF PORTAGE	6235 STERLING CREEK RD PORTAGE, IN 46368

(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) COMPLETION DATE
	Resident #K's daughter and writer decided it was better to send the resident to the ER for the treatment. The DON provided a list of the mediations given to Resident #K on 3/15/13 at 11:53 a.m. The list included: Cymbalta 30 mg (a medication used to treat depression), Famotidine 20 mg (medication used to treat stomach reflux), Folic acid 1 mg, Lisinopril/HCTZ 10/12.5 mg (medicaiton used to treat hypertension), and ibuprofen/Oxycodone 400/5 mg (narcotic/pain medication). Interview with the DON on 3/15/13 at 4:20 p.m., indicated the QMA had worked for the company for several years in another facility. The QMA's first day at this facility was 3/11/13. She will no longer be working in this facility. She did not follow the 5 rights to passing medications.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF PORTAGE	6235 STERLING CREEK RD PORTAGE, IN 46368

(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) COMPLETION DATE
R000407	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on record review and interview, the facility failed to ensure known infections were tracked and analyzed for residents diagnosed with and treated for skin infections for 2 residents in the sample of 13. (Residents #E and #G) Findings include: 1. The record for Resident #E was reviewed on 3/15/13 at 11:10 a.m. The resident's diagnoses included, but were not limited to, dementia, Alzheimer's disease, high blood pressure, dermatitis, and resolved scabies. The resident resided on the Memory Care unit. The 10/2102 Resident Notes were reviewed. An entry made on 10/23/12 at 9:00 a.m. indicated a few	R000407	To ensure this practice does not recur and provide systemic changes: All residents have the potential to be affected by this practice. All nurses and QMA's were educated on 03/28/2013 regarding infection control program. The Director of Nursing or designee will monthly track all infectious symptoms through reporting from pharmacy on antibiotic usage and monitoring of signs and symptoms of infection. To monitor the effectiveness of these corrective actions: The ED or designee will monthly review the infection control tracker with the Director of Nursing or designee.	04/15/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF PORTAGE	6235 STERLING CREEK RD PORTAGE, IN 46368

(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) COMPLETION DATE
	red dots were observed on the resident's chest and back. An entry made on 10/24/12 at 4:30 a.m. indicated the rash remained to the resident's chest and back areas. An entry made on 10/26/12 at 12:30 a.m. indicated the rash remained to the back of the residents arms, chest, and back. An entry made on 10/29/12 at 1:30 p.m. indicated minimal red raised non draining spots were observed to the resident's chest and back. The 11/2012 Resident Notes were reviewed. An entry was made on 11/7/12 at 4:20 p.m. This entry indicated the resident was observed with a rash to the face and trunk with flat pink non raised areas and complaints of itching. An entry made on 11/9/12 at 9:40 p.m. indicated the rash remained to the resident's chest, abdomen, and back. Review of the 11/8/12 Physician's Progress Note indicated the resident had a pruritic rash to the back and chest area. The Progress Note indicated the plan was for the the areas to be treated with Bactroban (an antibiotic ointment) and possible Dermatology follow up. Review of the 11/29/12 Physician			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF PORTAGE	6235 STERLING CREEK RD PORTAGE, IN 46368

(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) COMPLETION DATE
	Progress Note indicated the Impression was the resident had scabies(a contagious skin infection) and the Plan was to treat the resident with Permethrin (a topical medication used to treat scabies) and Atarax (a medication for for itching). The 11/2012 Physician orders were reviewed. An order was written on 11/18/12 for Bactroban cream to be applied twice a day and for staff to update the Physician in one week. An order was written on 11/26/12 to apply Elimite (an topical medication used to treat scabies) topically x one dose and to shower 12 hours after the application of the medication. A 11/26/12 prescription was written by a Physician from a Dermatology and Skin Surgery Center. The prescription indicated a scabies prep had been done and was positive for a diagnosis of scabies. The 9/2012 through 12/2102 Infection Control Logs for the Memory Care unit were reviewed on 3/15/13 at 3:00 p.m. There was no documentation of the resident's rash or diagnosis of and treatment for scabies on the 10/2012, 11/2012, or the 12/2012 Infection Control Logs.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/15/2013
NAME OF PROVIDER OR SUPPLIER RITTENHOUSE SENIOR LIVING OF PORTAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 6235 STERLING CREEK RD PORTAGE, IN 46368	

(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) COMPLETION DATE
	When interviewed on 3/15/13 at 5:01 p.m., the Memory Care unit supervisor indicated the resident's diagnosis and treatment of scabies should have been included on the Infection Control Logs. 2. The record for Resident #G was reviewed on 3/15/13 at 2:00 p.m. The resident's diagnoses included, but were not limited to, dementia, Alzheimer's disease, high blood pressure, peripheral vascular disease, and urinary incontinence. Review of a 10/24/12 Physician Fax/Order Request form indicated the Physician was notified by fax of a rash observed on the resident's back, bilateral upper legs, and right shoulder/chest area. The form also indicated the resident complained of itching. Review of the 10/2012 Medication Record indicated a Physician's order was initiated on 10/26/12 for Trimincolone 0.1 % cream 1:1 Cetaphil lotion twice a day and 8:00 a.m. and 8:00 p.m. An order for Bactroban cream (an antibiotic ointment) to be applied twice a day to the affected areas was initiated on 11/9/12.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF PORTAGE	6235 STERLING CREEK RD PORTAGE, IN 46368

(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) COMPLETION DATE
	Review of the 11/2012 Physician orders indicated an order was obtained on 11/8/12 for cultures to be obtained to the open areas on the resident's chest, back, and arms. The 11/2012 Laboratory test results were reviewed. The final results of the 11/8/12 chest area cultures were received on 11/9/12. The laboratory report indicated the rash on the the resident's chest was positive for numerous Staphylococcus aureus (an infection). The 9/2012 through 12/2102 Infection Control Logs for the Memory Care unit were reviewed on 3/15/13 at 3:00 p.m. There was no documentation of the resident's rash or diagnosis of and treatment for the Staphylococcus aureus infection on the 11/2012 or the 12/2012 Infection Control Logs. When interviewed on 3/15/13 at 3:30 p.m., the Memory Care LPN manager indicated the resident's skin infection should have been included on the Infection Control logs to monitor the infection. This state residential tag relates to Complaints IN00118331 and IN00120634.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF PORTAGE	6235 STERLING CREEK RD PORTAGE, IN 46368

(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) COMPLETION DATE