

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
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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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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: June 15 & 16, 2015</p> <p>Facility number: 012396 Provider number: 012396 AIM number: N/A</p> <p>Census bed type: Residential: 91 Total: 91</p> <p>Census payor type: Other: 91 Total: 91</p> <p>Sample: 9</p> <p>These state residential findings are cited in accordance with 410 IAC 16.2-5.</p>	R 0000	<p>The following is the Plan of Correction for the Rittenhouse Senior Living of Portage in regards to the Statement of Deficiencies dated June 16, 2015. 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.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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R 0144 Bldg. 00	<p>410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.</p> <p>Based on observation and interview, the facility failed to ensure the facility was clean and in a state of good repair related to dusty ceiling tiles, dirty and soiled carpets, marred walls and doors, and chipped and peeling paint on 2 of 2 Floors and the Memory Care Unit. (The First Floor, Second Floor and Memory Care Unit)</p> <p>Findings include:</p> <p>During the Environmental Tour on 6/15/15 at 2:20 p.m., with the Maintenance Director, the following was observed:</p> <p>1. The First Floor:</p> <p>a. In Room 102, the carpet in front of the sink and refrigerator was dirty and soiled. One resident resided in the apartment.</p> <p>b. In Room 113, the carpet throughout the entire apartment was dirty and soiled. The walls throughout the apartment were chipped and marred. One resident resided in the apartment.</p>	R 0144	<p>The following corrective action has been taken: 1. Apartments 102, 113, 202, hallway outside 240, and 321 had their carpets cleaned on June 16, 2015. 2. Apartments 113, 121, 235 and 314 were patched, painted, and repaired on 06/16/2015. 3. Ceiling tiles were cleaned on 06/23/2015. All residents have the potential to be affected by this practice. To ensure this practice does not recur and provide systemic changes: All resident rooms were audited on 06/17/2015 for cleanliness of carpets and marred walls. The Housekeeping Director or designee will monitor all resident rooms during weekly cleaning to ensure carpets and walls are clean and in good repair. Ceiling tiles will be monitored by the maintenance department on monthly preventative maintenance checklist. If carpets or walls are in need of cleaning or repair, Housekeeping Director and Maintenance Director or designee will complete them through the work order procedure. All staff were re-educated on the work order procedure on 06/25/2015. To monitor the effectiveness of these</p>	07/16/2015			

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	<p>c. In Room 121, the paint was peeling from the front door frame. One resident resided in the apartment.</p> <p>d. There was an accumulation of dust on the ceiling tiles next to the two vents in the hallway outside of the dining room.</p> <p>2. The Second Floor:</p> <p>a. In Room 202, the carpet in the living room was dirty and soiled. One resident resided in the apartment.</p> <p>b. In Room 235, the front door was marred. One resident resided in the apartment.</p> <p>c. There was a dried dark yellow substance on the hallway carpet outside of Room 240.</p> <p>3. The Memory Care Unit:</p> <p>a. In Room 314, the front door frame paint was chipped. One resident resided in the apartment.</p> <p>b. In Room 321, the carpet was dirty and soiled throughout the room. One resident resided in the apartment.</p> <p>Interview with the Maintenance Director</p>		<p>corrective actions: The ED or designee shall monitor for continued compliance by auditing the work orders Monday through Friday for 30 days. After 30 successful days of monitoring, auditing will go to weekly at the managers meeting for an indefinite amount of time. ED or designee will complete weekly rounds of the building for 4 weeks to ensure all work orders are completed. After 4 weeks of successful rounds, rounds will go to monthly for an indefinite amount of time.</p>	

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R 0349 Bldg. 00	<p>at the time, indicated the above areas were in need of cleaning and/or repair.</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to follow up documentation of a possible urinary tract infection for 1 of 7 records reviewed in the sample of 9. (Resident #6)</p> <p>Finding includes:</p> <p>The record for Resident #6 was reviewed on 6/15/15 at 10:50 a.m. The resident's diagnoses included, but were not limited to, neurogenic bladder and indwelling catheter due to chronic urinary tract infections.</p>	R 0349	The following corrective action has been taken: 1. Resident #6 was assessed by Home Health on 06/10/2015 and was found to have clear urine and catheter intact. On 06/16/2015, she was observed by the Nursing Department and was found asymptomatic for UTI. All residents have the potential to be affected by this practice. Director of Nursing and designee audited all resident records for proper follow up related to nursing documentation. To ensure this practice does not recur and provide systemic changes: All nursing staff are being re-educated on 06/25/2015 regarding proper follow up to documentation. To monitor the	07/16/2015

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R 0414 Bldg. 00	<p>An entry in the Nursing progress notes dated 6/6/15 at 3:00 a.m., indicated a CNA reported to the Nurse the resident had increased confusion and her foley catheter was draining cloudy yellow urine with thick white swirls. The resident had no complaints of discomfort and was afebrile. The resident's Physician was faxed at this time. There was no further documentation in the Nursing progress notes related to the resident's urine and follow up from the resident's Physician.</p> <p>Interview with the Director of Nursing on 6/16/15 at 12:45 p.m., indicated documentation should have completed in the Nursing progress notes to indicate the Home Health Agency had been contacted related to the resident's discolored urine.</p> <p>410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation and record review, the facility failed to ensure staff members washed their hands following glove removal for 1 of 5 residents observed during medication administration. (Resident #10)</p> <p>Finding includes:</p>	R 0414	<p>effectiveness of these corrective actions: The Director of Nursing or designee will audit the nurses report binder for follow up daily Monday through Friday and randomly audit 5 residents medical records weekly indefinitely. To monitor the effectiveness of these corrective actions: The ED or designee will monitor the audit reports at the weekly managers meeting.</p> <p>The following corrective action has been taken:</p> <p>1. LPN #1 was re-educated on facility policy and procedure for Handwashing and Infection Control.</p> <p>All residents have the potential to be affected by this practice.</p>	07/16/2015			

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	<p>On 6/16/15 at 8:38 a.m., LPN #1 was observed performing a glucometer for Resident #10. The LPN applied a pair of clean gloves and checked the resident's blood sugar. The LPN then removed the gloves and applied another pair of gloves to administer the resident's insulin. After administering the insulin, the LPN removed her gloves and assisted the resident to the dining room. After watching the resident take her oral medications at the dining room table, the LPN then proceeded to wash her hands with soap and water.</p> <p>The facility "Handwashing" policy was reviewed on 6/16/15 at 12:15 p.m. The Director of Nursing provided the policy and identified it as current. The policy indicated that alcohol rubs were an acceptable alternative to handwashing when in the same resident apartment working with a singular resident. The policy also indicated that it was the policy of the facility that handwashing was to be regarded as the single most important means of preventing the spread of infection.</p> <p>Interview with the Director of Nursing on 6/16/15 at 12:15 p.m., indicated the LPN should have washed her hands or used an alcohol gel after removing her gloves.</p>		<p>To ensure this practice does not recur and provide systemic changes:</p> <p>All staff were re-educated on 06/25/2015 regarding proper handwashing techniques and infection control.</p> <p>To monitor the effectiveness of these corrective actions:</p> <p>The Director of Nursing or designee will watch a nurse complete a blood glucose and insulin injection weekly until 4 continuous weeks of compliance have been met in regards to handwashing when completed. The Director of Nursing will then watch one blood glucose test and insulin injection monthly to ensure ongoing compliance. The results of these checks will be discussed at our weekly managers meeting.</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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