

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 08/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RITTENHOUSE SENIOR LIVING OF VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 VALE PARK RD VALPARAISO, IN 46383
---	--

(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	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey date: August 12, 2014</p> <p>Facility number: 012181 Provider number: N/A AIM number: N/A</p> <p>Survey team: Jennifer Redlin, RN-TC Caitlyn Doyle, RN Heather Hite, RN Julie Ferguson, RN</p> <p>Census bed type: Residential: 100 Total: 100</p> <p>Census payor type: Private: 100 Total: 100</p> <p>Sample: 7</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on August 14, 2014, by Janelyn Kulik, RN.</p>	R000000	Rittenhouse Senior Living of Valparaiso provides the following Plan of Correction "POC" without admitting or denying the validity or existence of the alleged deficiencies. The POC is prepared and/or executed solely because it is required by the provisions of federal and state law.	
R000241	410 IAC 16.2-5-4(e)(1)			

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.

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 08/12/2014	
NAME OF PROVIDER OR SUPPLIER RITTENHOUSE SENIOR LIVING OF VALPARAISO				STREET ADDRESS, CITY, STATE, ZIP CODE 1300 VALE PARK RD VALPARAISO, IN 46383			
(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			
	<p>Health Services - Offense</p> <p>(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:</p> <p>(1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on record review and interview, the facility failed to ensure physician's orders were followed, related to laboratory (lab) tests not completed as ordered and incorrect sliding scale insulin (insulin given per blood glucose test result) administration for 2 of 7 residents reviewed for physicians' orders in a total sample of 7. (Resident #1 and #7)</p> <p>Findings include:</p> <p>1. Resident #1's record was reviewed on 8/12/14 at 10:30 a.m. The resident's diagnoses included, but were not limited to, iron deficiency anemia, hyperlipidemia, and vascular dementia with delusions.</p> <p>Review of a Physician's Order, dated 7/6/14, indicated lab orders for a CBC (complete blood count), Iron, TIBC (iron blood test), and A1C (blood glucose test).</p> <p>Review of the lab results indicated the A1C, Iron, and TIBC lab tests had been completed on 7/8/14 along with a CMP</p>	R000241	<p>1. What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice? Resident #1-MD and responsible party were notified of incorrect lab being drawn. Correct lab will be drawn 8-26-14. The nurse responsible was educated on proper way to fill out the lab requisition and following physician orders. Res #7-all nurses were reinserviced regarding following physician orders and proper administration related to sliding scale insulin coverage</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected-facility will audit all charts of diabetic residents to ensure that all sliding scale insulin orders are being followed according to physician orders. All charts will be audited to ensure that all labs have been completed per physician order.</p> <p>3. What measures will be put in to place or what systemic changes the facility will make to ensure that the deficient practice does</p>	09/11/2014			

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 08/12/2014	
NAME OF PROVIDER OR SUPPLIER RITTENHOUSE SENIOR LIVING OF VALPARAISO				STREET ADDRESS, CITY, STATE, ZIP CODE 1300 VALE PARK RD VALPARAISO, IN 46383			
(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			
	<p>(comprehensive metabolic panel, electrolyte test). There was lack of documentation in the record to indicate the CBC had been completed as ordered.</p> <p>During an interview on 8/12/14 at 2:00 p.m., the Resident Care Coordinator (RCC) indicated a CMP had been completed instead of the CBC. She indicated all lab results were faxed directly to the Physician's office by the lab. She indicated she had checked with the Physician's office and no CBC results had been received. She further indicated the CBC had not been completed as ordered.</p> <p>2. The record for Resident #7 was reviewed on 8/12/14 at 1:00 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, hypertension, depression, and anxiety.</p> <p>Review of the Physician's Orders Summary, dated 8/2014, indicated orders written on 8/27/13 for sliding scale (insulin given per blood glucose test result) Humalog (insulin) injection 3 times per day, according to the following scales: Breakfast only: 120-180 = 4 units 181-200 = 6 units</p>		<p>not recur?The Resident Care Director/designee will audit the MARs of all diabetic residents with sliding scale insulin orders to ensure that the sliding scale insulin orders are followed per physician orders daily x 1 month then weekly x 4 weeks then monthly x 4. The Resident Care Director/designee will audit all resident records to ensure that labs are completed per physician order weekly x 2 months then monthly x 4 months then randomly to ensure that the labs are being completed per physician orders. The Resident Care Director/designee will then randomly audit resident records for compliance. All nurses will be inserviced regarding following physician orders related to sliding scale insulin administration and lab orders.4. How the corrective action(s) will be monitored to ensure the deficient practice does not recur, ie; what quality assurance program will be put in to place?The Resident Care Director/designee will complete audits as outlined above, the Executive Director will review audits for completion.</p>				

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 08/12/2014	
NAME OF PROVIDER OR SUPPLIER RITTENHOUSE SENIOR LIVING OF VALPARAISO				STREET ADDRESS, CITY, STATE, ZIP CODE 1300 VALE PARK RD VALPARAISO, IN 46383			
(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			
	<p>201-240 = 8 units 241-280 = 10 units 281-340 = 14 units</p> <p>Lunch & Dinner: < 120 = 0 units 120-150 = 4 units 151-200 = 6 units 201-240 = 8 units 241-280 = 10 units 281-340 = 8 units</p> <p>Notify MD (Physician) if BS (blood sugar) is < 70 or over 300.</p> <p>The Medication Administration Record (MAR) dated 5/2014, indicated the resident's blood glucose test result on 5/17/14 before breakfast was 100 and 4 units of insulin were given. The resident should not have received any insulin.</p> <p>The MAR dated 6/2014, indicated the resident's blood glucose test result 6/5/14 before lunch was 120 and 0 units of insulin were given. The resident should have received 4 units of insulin.</p> <p>The MAR dated 7/2014, indicated the resident's blood glucose test result 7/31/14 before dinner was 165 and the record lacked documentation any insulin was given. The resident should have received 6 units of insulin.</p>						

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 08/12/2014	
NAME OF PROVIDER OR SUPPLIER RITTENHOUSE SENIOR LIVING OF VALPARAISO				STREET ADDRESS, CITY, STATE, ZIP CODE 1300 VALE PARK RD VALPARAISO, IN 46383			
(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			
R000246	<p>The MAR dated 8/2014, indicated the resident's blood glucose test result 8/9/14 before breakfast was 169 and no insulin was given. The resident should have received 4 units of insulin.</p> <p>Interview with the Resident Care Coordinator on 8/12/14 at 3:20 p.m., indicated the insulin was not given as ordered and the insulin should have been given according to the sliding scale.</p> <p>A policy titled "Preparation for Medication Administration ... General Guidelines" was provided by the Administrator on 8/12/14 at 3:30 p.m. and deemed as current. The policy indicated, "... Documentation: u. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medication report off-duty without first recording the administration of any medications...."</p>						
	410 IAC 16.2-5-4(e)(6)						

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 08/12/2014	
NAME OF PROVIDER OR SUPPLIER RITTENHOUSE SENIOR LIVING OF VALPARAISO				STREET ADDRESS, CITY, STATE, ZIP CODE 1300 VALE PARK RD VALPARAISO, IN 46383			
(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			
	<p>Health Services - Deficiency</p> <p>(6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.</p> <p>Based on record review and interview, the facility failed to ensure as needed medication (PRN) was administered upon authorization by a licensed nurse or physician for 1 of 7 residents reviewed for PRN medication in a total sample of 7. (Resident #1)</p> <p>Findings include:</p> <p>Resident #1's record was reviewed on 8/12/14 at 10:30 a.m. The resident's diagnoses included, but were not limited to, iron deficiency anemia, hyperlipidemia, and vascular dementia with delusions.</p> <p>The Physician's Order Summary, dated 8/2014, indicated an order for Ativan (an antianxiety medication) 0.5 milligrams (mg) one tablet every six hours PRN (as needed) for agitation.</p> <p>The Medication Administration Record</p>	R000246	<p>1. What corrective action(s) will be accomplished for those residents found to be affected by deficient practice?QMA was reeducated regarding correct procedure for documentation protocol related to PRN medications2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents have the potential to be affected. Resident Care Director/designee will audit all resident records/Medication administration records (MARS) for nurse cosignature on PRN medications. Any QMA not in compliance with receiving nurse cosignature for PRN medications will be subject to reinstruction.3. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur?All nurses/QMAs will be reinserviced/reeducated on policy on documentation protocols for administration of PRN</p>	09/11/2014			

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 08/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RITTENHOUSE SENIOR LIVING OF VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 VALE PARK RD VALPARAISO, IN 46383
---	--

(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
	<p>(MAR), dated 5/2014, indicated the Ativan was administered by a QMA without prior authorization on 5/1/14.</p> <p>During an interview on 8/12/14 at 2:00 p.m., the Resident Care Coordinator (RCC) indicated the PRN medication had been given by a QMA. She further indicated she could not find documentation of prior authorization by the nurse.</p> <p>A facility policy, dated 2/1/14, and received from the RCC as current, titled, "Medication Administration by a QMA/PRN Medication," indicated, "...Nurse gives authorization for each dose of PRN medication identified by initials on line of narrative PRN documentation on back side of medication sheet or QMA PRN medication note may be initialed..."</p>		<p>medications.4. How the corrective action(s) will be monitored to ensure the deficient practice does not recur, ie; what quality assurance program will be put in to place?Resident Care Director/designee will audit MARs daily x 30 days then weekly x 4 weeks then monthly x 4 to ensure that all PRN medications administered by a QMA are cosigned by a licensed nurse. Executive Director will review and cosign audit tools for compliance.</p>	