

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 02/26/2016
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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 the Investigation of Complaint IN00193731.</p> <p>Complaint IN00193731-Substantiated. State residential deficiencies related to the allegations are cited at R0052.</p> <p>Unrelated deficiency is cited.</p> <p>Survey date: February 26, 2016</p> <p>Facility number: 012396 Provider number: 012396 AIM number: N/A</p> <p>Residential census: 95</p> <p>Sample: 3</p> <p>These state residential findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed by 26143, on March 4, 2016.</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 February 26, 2016. 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>	
R 0036 Bldg. 00	<p>410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the</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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	<p>resident ' s physician and the resident ' s legal representative when the facility has noticed:</p> <p>(1) a significant decline in the resident ' s physical, mental, or psychosocial status; or</p> <p>(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.</p> <p>Based on record review and interview, the facility failed to ensure the resident's physician was notified after the resident had an increase in behaviors for 1 of 3 records reviewed. (Resident #B)</p> <p>Finding includes:</p> <p>The record for Resident #B was reviewed on 2/26/16 at 11:25 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's and moderate Alzheimer's dementia.</p> <p>Documentation in the Nursing progress notes on 1/30/16 at 11:30 a.m., indicated the resident was yelling out frequently for juice and food prior to his meal and became disruptive.</p> <p>On 1/31/16, it was reported by the midnight Nurse that the resident had been up all evening and went to bed at approximately 5:30 a.m.</p> <p>Documentation in the Nursing progress</p>	R 0036	<p>The following corrective action has been taken:</p> <p>Resident B's neurologist was notified of his behaviors on 03/08/2016. Resident B's family had a meeting with nursing on 03/08/2016 to discuss behaviors and make a plan of action moving forward.</p> <p>All residents have the potential to be affected by this practice. To ensure this practice does not recur and provide systemic changes: All resident charts were audited on 03/18/2016 for change in conditions/proper notification. Nurses and QMA's were re-educated on physician/family notification on 03/18/2016. The DON or designee shall monitor for continued compliance by auditing the nurses report binder for proper physician/family notification Monday through Friday for 4 weeks. After 4 continuous weeks of compliance, audit will go to weekly indefinitely. To monitor the effectiveness of these corrective actions: ED or designee will monitor the audit reports at the weekly managers meeting.</p>	03/26/2016

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	<p>notes on 2/3/16 at 4:00 p.m., indicated the resident was very confused, not redirectable, being very mean and demanding toward staff. Walking in other resident rooms and yelling at staff when they tried to explain he couldn't be in there. The resident stated he was the boss and could do what he wanted. At 9:00 p.m., documentation indicated the resident was acting the same.</p> <p>On 2/16/16 at 6:00 p.m., documentation in the Nursing progress notes indicated the resident was very argumentative and demanding of staff. The resident was looking at papers behind the sink, staff told him it was dinner time and tried to show him to his seat, he told staff, "leave me alone, I can do what I want." The resident then raised a fist at the staff member.</p> <p>Documentation in the Nursing progress notes on 2/20/16 at 5:00 p.m., indicated the resident was going around the tables in the dining room and pulling female resident's hair and grouping their breasts. The resident got very argumentative when staff told him to stop. The resident continued to touch multiple female residents, staff got in between him and the female resident and the resident yelled at staff saying, "I can touch them if I want and I am going to put my fist in</p>			

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R 0052 Bldg. 00	<p>your face." Staff stood in between the residents until the resident left for his room. At 8:00 p.m., the resident was not staying on one task for more than a few minutes. He was also going in other resident rooms and pounding on doors and pushing his walker into some of the doors.</p> <p>There was no documentation of Physician notification of the resident's behaviors from 1/30-2/20/16.</p> <p>Interview with the Memory Care Coordinator on 2/29/16 at 2:30 p.m., indicated that she was not aware of the incident on 2/20/16. She also indicated the resident's Physician had not been notified of the resident's behaviors.</p> <p>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.</p> <p>Based on record review and interview, the facility failed to ensure 2 of 3 sampled residents were free from mental abuse. (Residents #B and #C)</p> <p>Finding includes:</p>	R 0052	The following corrective action has been taken: CNA's involved in the recordings were terminated on 02/16/2016. All residents have the potential to be affected by this practice. To ensure this practice does not recur and provide systemic changes:	03/26/2016

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	<p>During Orientation tour on 2/26/16 at 9:00 a.m., with the Memory Care Coordinator, Residents #B and #C were identified as being part of a recent State reportable investigation.</p> <p>The record for Resident #B was reviewed on 2/26/16 at 11:25 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's and moderate Alzheimer's dementia.</p> <p>An entry in the Nursing Progress notes dated 2/16/16 at 5:00 p.m., indicated a message was left for the resident's son to discuss resident unauthorized video being posted to social media.</p> <p>The record for Resident #C was reviewed on 2/26/16 at 10:30 a.m. The resident's diagnoses included, but were not limited to, delusional disorder, dementia, depression, and anxiety.</p> <p>An entry in the Nursing Progress notes dated 2/16/16 at 4:00 p.m., indicated the resident was with no noted anxiety or behaviors. The resident's son was notified about an unauthorized video being posted to social media and the action taken towards the employees.</p> <p>Review of the facility investigation of the</p>		<p>1.All staff were re-educated on 02/19/2016 regarding abuse, resident rights, HIPAA, and social media postings.</p> <p>2.During orientation, all new staff will be educated on abuse, resident rights, HIPAA, and social media postings.</p> <p>3.Annually and as needed based on outcome of audit reviews, all staff will be re-educated on abuse, resident rights, HIPAA, and social media postings.</p> <p>To monitor the effectiveness of these corrective actions: The ED or designee will randomly audit/observe/interview 5 employees including all shifts/departments per week for 8 weeks. After 8 weeks, 2 employees per week will be randomly audited/observed/interviewed indefinitely for continued compliance on what the policies are and report the findings weekly managers meeting.</p>				

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	<p>incident on 2/26/16 at 12:45 p.m., indicated the following:</p> <p>On 2/16/16 at approximately 12:30 p.m., the Executive Director (ED) received a phone call from a woman in the community who explained to the ED that she saw an inappropriate video on "Periscope" (a social media site) which had two employees of the facility in it and a couple of residents. The caller was upset about the video, felt it was totally inappropriate, and something needed to be done. The caller explained to the ED how to download the application, log on, and how to view the two videos. After viewing the videos, the ED immediately started an investigation into the videos, who was on them, and the nature of the videos. The two employees in the videos were found to be verbally inappropriate and in violation of resident rights. Both employees were being terminated as of today. CNA #1 was taking the video and talking about the residents being up at 3:00 a.m. for no good reason. She stated she didn't know why their "a...." were up wandering around. CNA #2 was heard talking inappropriately to Resident #B stating that he couldn't eat corn starch that it was to cook with, then he responded with "good to know" and she said go ahead and eat it with your mustard, I don't care. He then proceeded</p>			

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	<p>to the table and sat down with Resident #C. He asked CNA #2 what was wrong with Resident #C and the CNA responded "I don't care and I don't know why you care." The CNA then proceeded to tell Resident #B that he was making the other resident feel bad for being OCD (obsessive compulsive disorder).</p> <p>The ED interviewed the CNA's on 2/16/16. Interview with CNA #2 at 3:15 p.m., indicated she was only joking with the resident over the corn starch and mustard. She also indicated Resident #B kept asking about Resident #C scratching her leg. The CNA indicated that she was not trying to be inappropriate and she was joking with the resident and she felt like the resident was joking back with her. The CNA indicated that she had no idea that she and the residents were being recorded.</p> <p>Interview with CNA #1 at 5:22 p.m., indicated that when asked about recording of residents, she first denied recording anything. When ED informed the CNA that she had seen the videos, she then admitted to taking a video and she said she did not mean to post anything. When asked why she would even take the video, she just said "because" and I have no reason for my actions.</p>			

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	<p>Both CNA's were terminated on 2/16/16 for posting unauthorized video and inappropriate behavior towards the residents which was in direct violation of HIPAA, the facility's Social Networking Policy and the Employee Handbook. The Employee Handbook indicated, "Residents are to be treated with dignity and respect at all times and under all circumstances. Mistreatment will not be tolerated. Any employee found abusing or neglecting a resident will be subject to immediate termination."</p> <p>Interview with the Memory Care Coordinator on 2/26/16 at 2:15 p.m., indicated after she and the Executive Director found out about the videos, a full investigation was started. The CNA's were fired and facility wide inservicing was done related to abuse, resident rights, social media, and HIPAA.</p> <p>This State residential finding is related to Complaint IN00193731.</p>			