

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 11/15/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RITTENHOUSE SENIOR LIVING OF MICHIGAN CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 4300 CLEVELAND RD MICHIGAN CITY, IN46360
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
R0000	<p>This visit was for a State Licensure Survey.</p> <p>Dates of Survey: November 14 &amp; 15, 2011</p> <p>Provider Number: 012180 Facility Number: 012180 AIM Number: N/A</p> <p>Survey Team: Heather Tuttle, R.N. T.C. Kathleen Vargas, R.N.</p> <p>Census Bed Type: 64 Residential 64 Total</p> <p>Census Payor Type: 64 Other 64 Total</p> <p>Sample: 8</p> <p>These State Residential Findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review 11/18/11 by Suzanne Williams, RN</p>	R0000	<p>Re: Survey event ID OHYW11Please accept this as our credible alligation. Respectfully,Debbie Tanksley</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.

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 11/15/2011	
NAME OF PROVIDER OR SUPPLIER  RITTENHOUSE SENIOR LIVING OF MICHIGAN CITY				STREET ADDRESS, CITY, STATE, ZIP CODE 4300 CLEVELAND RD MICHIGAN CITY, IN46360			
(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			
R0154	<p>(k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24.</p> <p>Based on observation and interview, the facility failed to keep the kitchen clean related to a build up of adhered dirt and dried food spillage behind and under the steam table and on the sides of the stove, steamer and inside the convection ovens for 1 of 1 kitchen. This had the potential to affect 64 of 64 residents who resided in the facility. (The Main Kitchen)</p> <p>Findings include:</p> <p>On 11/14/11 at 9:43 a.m., during the Full Kitchen Sanitation Tour in the Main Kitchen, the following was observed:</p> <p>A. A large amount of dried food spillage and grease was observed on both sides of the stove.</p> <p>B. There was a large amount of dried food spillage observed on both sides of the steamer.</p> <p>C. There was a moderate amount of black dried food spillage observed inside and below the metal racks in the convection ovens.</p> <p>D. There was a large amount of dirt and</p>	R0154	<p>Please accept this as our credible allegation... R 154 The corrective action was taken immediately. Immediately staff began cleaning the affected areas listed for the main Kitchen to ensure no resident would be affected by this deficient practice. Item's A, B, C, and D were cleaned and sanitized with in an hour of the full Kitchen tour by the State Department of Health. Immediate cleaning was completed within the hour to ensure no resident would be affected by this deficient practice. The measures and systemic changes for A, B, C, and D are as follows: A daily audit form was developed to include all Items for A, B, C, and D. Please see attached audit sheet. All of the above will be audited daily by the Dietary Food Manager and / or Cooks along with random inspections from the Executive Director. This practice will be ongoing indefinitely to ensure deficient practice does not recur. The corrective actions will be monitored by the Dietary Food Manager, the Cooks, and the Executive Director indefinitely. The date systemic changes will be completed will be 11-30-11</p>	11/30/2011			

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 11/15/2011	
NAME OF PROVIDER OR SUPPLIER  RITTENHOUSE SENIOR LIVING OF MICHIGAN CITY				STREET ADDRESS, CITY, STATE, ZIP CODE 4300 CLEVELAND RD MICHIGAN CITY, IN46360			
(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			
R0349	<p>food particles observed behind and under the steam table. At that time, the Dietary Food Manager pulled the table (located next to the steam table) away from the wall. There was adhered dirt and the floor tile was yellow discolored behind this table and behind the steam table.</p> <p>Interview with the Dietary Food Manager at that time, indicated all of the above were in need of cleaning.</p> <p>(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 ensure the resident's clinical record was accurately documented related to medication administration instructions for 1 of 7 resident records reviewed for accuracy in a sample of 8. (Resident #6)</p> <p>Findings include:</p> <p>The record for Resident #6 was reviewed on 11/14/11 at 2:15 p.m. The resident was admitted to the facility on 8/17/11.</p>	R0349	R 349 Resident #6 was a discharged resident record. Therefore, the resident will no longer be affected by deficient practice. All resident chrs were audited. Please see attached audit sheet. The Audit ensures all physicians' orders were transcribed correctly. No other residents were found to be affected by the deficient practice. A monthly Audit form is in place to ensure Physician Orders are transcribed accurately. The Resident Care Director will perform and sign the audit sheet monthly. The audit will then go to the Executive Director for	11/30/2011			

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 11/15/2011	
NAME OF PROVIDER OR SUPPLIER  RITTENHOUSE SENIOR LIVING OF MICHIGAN CITY				STREET ADDRESS, CITY, STATE, ZIP CODE 4300 CLEVELAND RD MICHIGAN CITY, IN46360			
(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>The resident had diagnoses that included, but were not limited to, hypertension, anxiety, and osteoarthritis.</p> <p>There was a physician's order dated 8/20/11, that indicated Colace (a stool softening medication) 100 mg (milligrams) was to be administered daily. A physician's order dated 8/23/11 indicated the Colace was to be increased to twice a day.</p> <p>Review of the September 2011 Physician Order Sheet (POS) indicated Colace 100 mg was to be administered daily. Review of the September 2011 Medication Administration Record (MAR) indicated the Colace was to be administered daily.</p> <p>Interview with the Resident Care Director on 11/15/11 at 9:25 a.m., indicated the resident's record was not accurate. She indicated the physician's order dated 8/23/11, was not transcribed accurately to the September 2011 Physician Order Sheet and to the September 2011 Medication Administration Record. She indicated the Colace was to be administered twice daily as ordered by the Physician on 8/23/11.</p>		<p>review. The Resident Care Director will audit the transcribed physician's orders monthly to ensure all physician orders were transcribed correctly before the next month begins. The Executive Director will receive a copy of the audit each month for review. The audit process will continue indefinitely to ensure deficient practice does not recur. The date systemic changes will be completed will be 11-30-11</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 11/15/2011	
NAME OF PROVIDER OR SUPPLIER  RITTENHOUSE SENIOR LIVING OF MICHIGAN CITY				STREET ADDRESS, CITY, STATE, ZIP CODE 4300 CLEVELAND RD MICHIGAN CITY, IN46360			
(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			
R0356	<p>(i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following:</p> <p>(1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth.</p> <p>(2) The resident ' s hospital preference.</p> <p>(3) The name and phone number of any legally authorized representative.</p> <p>(4) The name and phone number of the resident ' s physician of record.</p> <p>(5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death.</p> <p>(6) Information on any known allergies.</p> <p>(7) A photograph (for identification of the resident).</p> <p>(8) Copy of advance directives, if available.</p> <p>Based on record review and interview, the facility failed to ensure each resident's emergency information file was updated related to the resident's hospital preference for 2 of 5 residents reviewed for emergency information files in the sample of 8. (Resident's #3 &amp; #4)</p> <p>Findings include:</p> <p>1. The record for Resident #3 was reviewed on 11/14/11 at 1:00 p.m. The resident was admitted to the facility on 8/29/11.</p> <p>Review of the Resident's emergency information file book indicated the</p>	R0356	R 356 For residents #3 and #4 ... The emergency information file books were immediately updated to indicate the resident's hospital preference. All other residents' emergency information forms were immediately audited to insure no other resident was affected by this deficient practice. The measures and systemic changes in place to ensure this deficient practice does not recur are as follow: An audit form was developed to include the resident hospital preference to be checked on the audit form for each admission. Please see attached form. The audit form will include the resident's hospital preference as a check off sheet. The admission coordinator will ensure the check off sheet is complete.	11/30/2011			

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 11/15/2011	
NAME OF PROVIDER OR SUPPLIER  RITTENHOUSE SENIOR LIVING OF MICHIGAN CITY				STREET ADDRESS, CITY, STATE, ZIP CODE 4300 CLEVELAND RD MICHIGAN CITY, IN46360			
(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			
R0408	<p>resident's hospital preference was blank and not completed.</p> <p>Interview with the Resident Care Director on 11/14/11 at 3:00 p.m., indicated the resident's hospital preference for the emergency information file book should have been filled in and completed.</p> <p>2. The record for Resident #4 was reviewed on 11/14/11 at 1:15 p.m. The resident was admitted to the facility on 5/6/11.</p> <p>Review of the book which contained the resident's emergency information file on 11/4/11 at 1:15 p.m., indicated the emergency information file for Resident #4 was not complete. The resident's hospital preference was not indicated on the form.</p> <p>Interview with the Administrator on 11/14/11 at 1:15 p.m., indicated the emergency information file was not complete. She indicated the hospital preference for Resident #4 was not completed on the emergency information file form.</p> <p>(c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. Based on record review and interview, the</p>	R0408	The Resident Care Director and / or the Executive Director will audit and sign off on the audit sheet for each admission to ensure the hospital preference is indicated. This practice will be ongoing indefinitely. The date systemic changes will be completed will be 11-30-11.	11/30/2011			

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 11/15/2011	
NAME OF PROVIDER OR SUPPLIER  RITTENHOUSE SENIOR LIVING OF MICHIGAN CITY				STREET ADDRESS, CITY, STATE, ZIP CODE 4300 CLEVELAND RD MICHIGAN CITY, IN46360			
(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>facility failed to ensure each resident had a diagnostic chest x-ray completed within 6 months prior to admission for 1 of 7 residents reviewed for chest x-rays in a sample of 8. (Resident #4)</p> <p>Findings include:</p> <p>The record for Resident #4 was reviewed on 11/14/11 at 1:15 p.m. The resident was admitted to the facility on 5/6/11.</p> <p>The form titled "Immunization Record" was reviewed. It indicated the resident had a diagnostic chest x-ray completed on 10/20/10, more than 6 months prior to admission to the facility.</p> <p>Review of the radiology reports indicated a chest x-ray report for the resident that was dated 10/20/10. There were no additional chest x-ray reports dated 10/21/10 through 5/6/11.</p> <p>Interview with the Resident Care Director on 11/15/11 at 9:25 a.m., indicated she was aware the resident's chest x-ray had not been completed within the 6 months prior to the resident's admission to the facility.</p>		<p>For resident # 4 the Resident Care Director checked to confirm a TB test was completed on Resident #4. A TB Test was negative. On 9-7-11 resident #4 had another chest x-ray completed. The 9-7-11 chest x-ray was normal.</p> <p>The Resident Care Director completed an audit on every resident chart to ensure every resident was in compliance with a diagnostic chest x-ray that was completed with in 6 months prior to admission. No other resident was affected by the deficient practice.</p> <p>The measures and systemic changes were made to ensure this deficient practice does not recur is as follows: An audit form has been developed for the Admissions Coordinator to use for each admission to ensure the resident chest x-ray is within the required 6 months prior to admission expectation.</p> <p>An audit form was developed to include the chest x-ray along with the admission paperwork check list. The executive director and / or the Resident Care Director will audit each admission ongoing and indefinitely to ensure the resident chest x-ray is completed within the 6 months prior to admission expectation.</p> <p>The date systemic changes will</p>				

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

PRINTED: 12/01/2011

FORM APPROVED

OMB NO. 0938-0391

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 11/15/2011
NAME OF PROVIDER OR SUPPLIER  RITTENHOUSE SENIOR LIVING OF MICHIGAN CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 4300 CLEVELAND RD MICHIGAN CITY, IN46360		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
			be completed will be 11-30-11.		