

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 06/10/2015
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NAME OF PROVIDER OR SUPPLIER RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1251 W 96TH ST INDIANAPOLIS, IN 46260
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: June 9 and 10, 2015</p> <p>Facility number: 003282 Provider number: N/A AIM number: N/A</p> <p>Census bed type: Residential: 79 Total: 79</p> <p>Census payor type: Medicaid: 12 Other: 67 Total: 79</p> <p>Sample: 8</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p>	R 0000	<p><u>DISCLAIMER: Preparation and implementation of this plan of correction does not constitute admission or agreement by Rittenhouse Senior Living of Indianapolis of the truth of the facts, findings, or other statements as alleged by the preparer of the survey/inspection dated June 10, 2015. Rittenhouse Senior Living of Indianapolis specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action not related directly to the licensing and/or certification fo this facility or provider. Rittenhouse Senior Living respectfully requests a paper review for compliance for the annual survey.</u></p>	
R 0092 Bldg. 00	<p>410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of</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>emergency as follows:</p> <p>(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.</p> <p>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>Based on record review and interview, the facility failed to ensure fire and disaster drills were conducted quarterly on each shift. This deficient practice had the potential to effect 79 residents living in the facility.</p> <p>Findings Include:</p> <p>Review of the fire and disaster drill log for June 30, 2014 through May 28, 2015, was completed on June 9, 2015 at 10:48 a.m. It indicated the following:</p> <p>Third quarter 2014: fire drills were conducted on June 20, 2014 at 9:30 a.m., first shift and August 29, 2014 at 8:00</p>	R 0092	-	07/15/2015	
			<p>The immediate corrective action was a fire drill was held on the third shift on 6/16/2015.</p> <p>All resident in the community have the potential to be affected so the fire drill was conducted shortly after the item was discovered. (On 6/16/2015)</p> <p>To prevent this oversight from happening again a form was drafted and placed in front of the fire drill records that clearly shows if a drill is missing on a particular shift for each quarter. A copy of this form is attached. The Maintenance</p>		

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	<p>a.m., first shift. No fire drill was conducted on the second or third shifts.</p> <p>Fourth quarter 2014: fire drills were conducted on October 3, 2014 at 11:02 a.m., first shift, November 12, 2014 at 3:00 p.m., second shift and December 23, 2014 at 2:15 p.m., second shift. No fire drill was conducted on the third shift.</p> <p>First quarter 2015: fire drills were conducted on January 11, 2015 at 11:30 a.m., first shift, February 3, 2015 at 5:45 p.m., second shift and March 31, 2015 at 3:30 p.m., second shift. No fire drill was conducted on the third shift.</p> <p>During an interview on June 10, 2015 at 9:00 a.m., the Maintenance Director indicated he had conducted the fire drills and the documentation should have been in the log book. No further information was provided.</p> <p>During an interview on June 10, 2015 at 11:00 a.m., the Administrator indicated she had not looked at the log book but thought the fire drills were being conducted as necessary. The Administrator indicated she would look into the concern. No further information was provided.</p>		<p>Director will perform all fire drills as required by regulation. He was in-service and provided a copy of the regulations. The Executive Director will monitor the records quarterly to make sure they are up to date.</p> <p>All items we completed by 6/26/2015</p>				

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R 0154 Bldg. 00	<p>410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (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, interview and record review, the facility failed to maintain a clean freezer and to label food items in the freezer. This deficiency had the potential to affect 79 of 79 residents receiving food from the kitchen.</p> <p>Findings include:</p> <p>On 6/9/15 at 9:05 a.m., the sanitation and safety tour of the kitchen was started with Cook #1. He indicated he was one of the cooks and the Dietary Manager was not in the facility.</p> <p>During the tour, Freezer #1 was observed to have left over ice cream in bowls on a cookie sheet. The ice cream was not covered or dated. A bag of frozen cookies was observed in an open box. The box was undated. A bag of frozen biscuits was observed in an open box. The box was undated.</p> <p>In Freezer #2, a box of hotdogs was observed opened. The plastic bag was</p>	R 0154	<p>The immediate corrective action was for all unlabeled food items to be discarded or if appropriate, covered, labeled and dated. All residents have the potential to be affected so all unlabeled food was labeled or discarded as appropriate. The Dietary Services Manager will in-service all staff on appropriate labeling to ensure this does not happen again. The Charge person on each shift will be responsible for checking every day for food that is not labeled and dated and making sure it is labeled/dated. She will also report to the DSM anyone who fails to follow policy on labeling and dating food. The DSM will check this each day worked to ensure labeling and dating appropriately is taking place. All items will be corrected by 7/15/2015.</p>	07/15/2015			

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R 0247	<p>twisted and placed back into the undated box. A box of bratwurst was observed opened. The plastic bag was twisted and placed back into the undated box. A box of polish sausage was observed opened. The plastic bag was twisted and placed back into the undated box. An opened, frozen bag was observed without the contents identified or a date on the bag</p> <p>During an interview on 6/9/15 at 9:10 a.m., Cook # 1 indicated staff were to date all items that were opened. He indicated all items should have had a date.</p> <p>Review of a current, undated facility policy titled "Storage of Refrigerated and Dry Foods", provided by the Administrator on 6/9/15 at 11:10 a.m., included the following:</p> <p>"1. Fresh fruits, vegetables, eggs....</p> <p>...4. All containers must be labeled with the contents and date food item was opened...."</p> <p>No additional policies were provided related to frozen food items.</p> <p>410 IAC 16.2-5-4(e)(7) Health Services - Deficiency</p>			

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Bldg. 00	<p>(7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents received the correct dose of medication according to the current physician order for 2 of 5 residents reviewed during medication administration. (Resident #10 and #61). The facility also failed to ensure a medication error rate of less than 5 percent for 2 of 12 medications observed affecting 2 of 5 residents resulting in a medication error rate of 16.6%. (Resident #10 and #61; LPN #2 and LPN #3)</p> <p>Findings include:</p> <p>1. During medication administration observation on 6/9/15 at 12:05 p.m., LPN #2 was unable to find Resident #10's insulin in her cart. She proceeded to the medication refrigerator and removed a vial of Novolin R from the Emergency Drug Kit (EDK) for Resident #10. She administered 2 units to Resident #10.</p> <p>During review of the Medication Administration Record (MAR), the</p>	R 0247	<p>The immediate corrective action for the insulin was the resident glucose was rechecked and found to be within normal limits and the correct medicine was ordered for the resident. The physician and family were notified. The immediate corrective action for the Advair was the resident was rechecked and found to be without any adverse effects and the correct medicine was ordered for the resident. The physician and family were notified.</p> <p>Since this has the potential to affect all resident, all licensed staff and QMAs were in serviced on medication administration.</p> <p>Medication administration will be observed weekly for four weeks then monitored monthly. Either the Director of Nursing or her designee will perform the weekly and monthly checks.</p> <p>The Director of nursing will be responsible for making sure the weekly and monthly observations are completed and for following up with any additional training needed if needed.</p>	07/15/2015

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	<p>current physician's order indicated Resident #10 should have received Novolog.</p> <p>During an interview on 6/9/15 at 1:30 p.m., the DON indicated the Physician was notified of the error and the resident's blood glucose was rechecked and found to have been within normal limits.</p> <p>2. During medication administration observation on 6/9/15 at 3:26 p.m., LPN #3 gave Resident #61 an inhaled dose of Spiriva (bronchodilator) 18 Mcg. The Spiriva inhaler was documented as having been given at 8:00 a.m. on 6/9/15 by a different nurse.</p> <p>During review of the Medication Administration Record (MAR), the current physician's order indicated Resident #3 should have received Advair (bronchodilator) 250-50. Resident #3 received Spiriva once daily in the morning and Advair twice daily.</p> <p>There were 12 opportunities for medication errors during the medication pass observations. Two errors resulted. This made the error rate equal to 16.6%.</p> <p>3. Review of a current facility policy, dated 4/30/2008, titled "8.6 Medication</p>		All items will be completed by July 15, 2015.				

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R 0273 Bldg. 00	<p>Administration: General Guidelines", which was provided by the DON on 6/10/15 at 10:00 a.m., indicated the following:</p> <p><u>Purpose</u> To promote a safe environment for residents, to respect the rights of each resident,...</p> <p><u>PROCESS</u></p> <p>...11. Observe the seven "rights" of medication administration: right resident, right medication, right dose, right route, right time, right to know about the medication, and right to refuse medication.</p> <p>12. Administer medications in accordance with physician's order...."</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure a sanitary environment in the food</p>	R 0273	The immediate corrective action was for staff to put on hair nets. All residents have the potential to be affected so	07/15/2015			

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	<p>preparation area of the kitchen. This deficiency had the potential to affect 79 of 79 residents who received food from the kitchen. (FSA[Food Service Assistant] #4 and #5).</p> <p>Findings include:</p> <p>On 6/9/15 at 9:05 a.m., the sanitation and safety tour of the kitchen was started. Upon entry into the kitchen, FSA #4 was observed without hair covering on.</p> <p>FSA #5 was walking from the kitchen without hair covering on. She indicated she was headed to the bathroom.</p> <p>FSA #4 was observed a few moments later with hair covering on. He indicated he did just put the covering on.</p> <p>The Dietary Manager was unavailable for an interview.</p> <p>During an interview on 6/10/15 at 11:45 a.m., the Director of Nursing (DON) indicated staff were aware if they were in the kitchen, they needed to wear hair coverings.</p> <p>Review of a current, undated facility policy titled "Employee Hygiene", provided by the Administrator on 6/9/15 at 11:10 a.m., included the following:</p>		<p>all staff were observed and instructed to wear hair nets. The Dietary Services Manager will in-service all staff on community hair net policy and counsel those who fail to follow policy to ensure this does not happen again. The Charge person on each shift will be responsible for checking every day that all staff are wearing hair nets before entering the food prep areas. She will also report to the DSM anyone who fails to follow policy. The DSM will check this each day worked to ensure hair nets are being worn in accordance with facility policy. All items will be corrected by 7/15/2015.</p>				

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R 0306 Bldg. 00	<p>"...6. Employees must keep hair from contacting exposed food, clean environment, utensils and linens. Exposed hair must be covered with hairnet, hat, etc...."</p> <p>410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug.</p> <p>Based on observation, interview and record review, the facility failed to properly ensure medication carts were free of loose pills for 2 of 2 carts observed during medication storage (Front Hall and Back Hall carts).</p> <p>Findings include:</p>	R 0306	<p>The immediate corrective action was the medication cart was inspected and cleaned.</p> <p>Since this has the potential to affect all resident, all licensed staff and QMAs were in serviced on medication administration, disposal and checking of medication carts.</p>	07/15/2015

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	<p>1. During inspection on 6/10/15 at 9:15 a.m., the Back Hall medication cart was found to have 8 whole, unidentified pills in the cart. The cart also had 3 -1/2 unidentified pills. The pills were loose inside the cart. LPN #2 identified some of the pills as risperidone (treatment for schizophrenia), Metoprolol (treatment for high blood pressure), Januvia (treatment for high blood glucose), magnesium oxide and vitamin D-3 2000. The other pills were not identified.</p> <p>2. During inspection of the Front Hall medication cart on 6/19/15 at 10:00 a.m., 5 whole pills were found loose inside the cart. Nine 1/2 pills were found loose inside the cart. The nurse did not identify the pills.</p> <p>During an interview on 6/9/15 at 9:30 a.m., LPN #9 indicated she threw the 1/2 pills into the trash. She was unsure of the facilities medication disposal policy.</p> <p>During an interview on 6/10/15 at 11:50 a.m., the Director of Nursing (DON) indicated LPN #9 told her she threw the pills into the trash. She indicated the facility did not have a specific policy for disposal of loose pills. She indicated the facility contracts with a pharmacy company for cart audits. She indicated the carts were last audited on 5/16/15.</p>		<p>Medication administration will be observed weekly for four weeks then monitored monthly. This will include checking the cart for loose pills. Either the Director of Nursing or her designee will perform the weekly and monthly checks.</p> <p>The Director of nursing will be responsible for making sure the weekly and monthly observations are completed and for following up with any additional training needed if needed.</p> <p>All items will be completed by July 15, 2015.</p>	

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	<p>Review of a current facility policy dated 4/30/2008, titled "8.6 Medication Administration: General Guidelines", which was provided by the DON on 6/10/15 at 10:00 a.m., indicated the following:</p> <p><u>Purpose</u> To promote a safe environment for residents, to respect the rights of each resident,...</p> <p><u>PROCESS</u></p> <p>...17. Do not administer a medication if you note a change in its color, consistency, and/or odor or if the drug is expired...."</p>			