

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/01/2024	
NAME OF PROVIDER OR SUPPLIER WINDWARD POINTE SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 6235 STERLING CREEK RD, PORTAGE, , 46368					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...		(X5) COMPLETION DATE		
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00421674. Complaint IN00421674 - State deficiencies related to the allegations are cited at R185, R240 and R349. Survey date: February 1 2024. Facility number: 012396 Residential Census: 88 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 2/8/24.	R 0000	The following is the plan of correction for the Rittenhouse Village at Portage in regards to the statement of deficiencies dated February 1, 2024. 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				

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			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.	
R 0185	Physical Plant Standards - Noncompliance 410 IAC 16.2-5-1.6(i)(1-2)(A)(i-iii)(B-E) (i) The facility shall house residents only in areas approved by the director for housing and given a fire clearance by the state fire marshal. The facility shall: (1) Have a floor at or above grade level. A facility whose plans were approved before the effective date of this rule may use rooms below ground level for resident occupancy if the floors are not more than three (3) feet below ground level. (2) Provide each resident the following items upon request at the time of admission:	R 0185	1.What corrective actions will be accomplished for those residents found to have been affected by Resident will be given a working Call button and staff will be Reeducated on how to report when a call button isn't working. 2.How will the facility identify other residents having the potential to be affected by the same deficient practice and what	03/01/2024

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	(A) A bed: (i) of appropriate size and height for the resident; (ii) with a clean and comfortable mattress; and (iii) with comfortable bedding appropriate to the temperature of the facility. (B) A bedside cabinet or table with a hard surface and washable top. (C) A cushioned comfortable chair. (D) A bedside lamp. (E) If the resident is bedfast, an adjustable over-the-bed table or other suitable device. (3) Provide cubicle curtains or screens if requested by a resident in a shared room. (4) Provide a method by which each resident may summon a staff person at any time. (5) Equip each resident unit with a door that swings into the room and opens directly into the corridor or common living area. (6) Not house a resident in such a manner as to require passage through the room of another resident. Bedrooms shall not be used as a thoroughfare. (7) Individual closet space. For facilities and additions to facilities for which construction plans are submitted for approval after July 1, 1984, each resident room shall		corrective action will be taken? All resident call buttons will be Checked to ensure they are working Properly and if button is not working Their call button will be replaced Immediately. 3. What measures will be put into place or what systematic changes the facility will ensure that the deficient practice does not occur? ED and DON will receive emails from The response care system that notifies When a call light button has low battery and/or is not working properly/ How will the corrective actions be monitored to ensure the deficient practice will not recur, what quality assurance programs in place? ED and DON will receive emails Daily stating when call button Battery is low/not working. Malfunctioning call buttons that	
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have clothing storage that includes a closet at least two (2) feet wide and two (2) feet deep, equipped with an easily opened door and a closet rod at least eighteen (18) inches long of adjustable height to provide access by residents in wheelchairs.

Based on observation and interview, the facility failed to ensure every resident had a functional method to call for assistance for 1 of 3 resident call systems observed.
(Resident B)

Finding includes:

On 2/1/24 at 8:30 a.m., Resident B was observed seated in his wheelchair in his bathroom. He indicated he couldn't find a washcloth or a clean towel. He had not called for assistance, but would do so. He pressed the pendant button he wore around his neck. He indicated he didn't know if it was working because nothing happened.

Near the nurses' station on the main floor, several staff were observed. There was no sound noted that a call light had been activated.

During an interview with CNA 1, on 2/1/23 at 8:35 a.m., she indicated the calls were sent to a pager that the aides carried. She didn't have her pager with her at that time, but they could

were fixed willBe discussed monthly at QA.

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also check the panel in the nurses' station to see if any call light was on, but it did not make any sound. She checked the panel and indicated no call lights were on. The CNA was made aware that Resident B had pressed his call light several minutes ago. She indicated he was having trouble with his call light yesterday also.

During an interview with the Executive Director, on 2/1/24 at 10:49 a.m., she indicated staff should notify them immediately if a pendant wasn't working and she would get the resident a new one.

This citation relates to Complaint IN00421674.

Based on observation and interview, the facility failed to ensure every resident had a functional method to call for assistance for 1 of 3 resident call systems observed.
(Resident B)

Finding includes:

On 2/1/24 at 8:30 a.m., Resident B was observed seated in his wheelchair in his bathroom. He indicated he couldn't find a washcloth or a clean towel. He had not called for assistance, but would do so. He pressed the pendant button he wore around his neck. He indicated he didn't know if it was working because nothing

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	happened. Near the nurses' station on the main floor, several staff were observed. There was no sound noted that a call light had been activated. During an interview with CNA 1, on 2/1/23 at 8:35 a.m., she indicated the calls were sent to a pager that the aides carried. She didn't have her pager with her at that time, but they could also check the panel in the nurses' station to see if any call light was on, but it did not make any sound. She checked the panel and indicated no call lights were on. The CNA was made aware that Resident B had pressed his call light several minutes ago. She indicated he was having trouble with his call light yesterday also. During an interview with the Executive Director, on 2/1/24 at 10:49 a.m., she indicated staff should notify them immediately if a pendant wasn't working and she would get the resident a new one. This citation relates to Complaint IN00421674.			
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall	R 0240	1.What corrective actions will be accomplished for those residents	03/01/2024

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be provided based upon individual needs and preferences.

Based on record review and interview, the facility failed to ensure dependent residents received the necessary ADL (activities of daily living) assistance, related to showers as scheduled, for 3 of 3 residents reviewed for ADL care. (Residents B, C and D) The facility also failed to follow up for treatment of a new open area for 1 of 3 residents reviewed for skin conditions. (Resident D)

Findings include:

1. The record for Resident B was reviewed on 2/1/24 at 9:00 a.m. Diagnoses included, but were not limited to, spinal stenosis, heart disease and osteoarthritis.

A Service Plan, dated 1/24/24, indicated the resident required physical assistance for showers.

Shower sheets and shift reports for December 2023 and January 2024 indicated showers were given only on the following dates:

12/2/23-refused

12/5/23

12/9/23

found to have been affected by deficient practice? Those residents needing assistance with Showers will be given showers two Times weekly with proper documentation Of showers given and/or refused. The resident with lack of documentation In chart about open area will have updated documentation with current condition, skin assessment, and follow up.

2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? DON will review the assignment sheets Indicating which residents need assistance With showers to ensure it is up to date. DON or designee will reeducate staff on properly documenting when showers are given and/or refused. DON or designee will review all residents with open

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12/12/23-refused 12/19/23 1/14/24 1/16/24-refused 1/27/24 2. The record for Resident C was reviewed on 2/1/24 at 9:36 a.m. Diagnoses included, but were not limited to, mild cognitive impairment and diabetes mellitus. A Service Plan, dated 8/27/23, indicated the resident needed assistance with bathing. Shower sheets and shift reports for December 2023 and January 2024 indicated showers were given only on the following dates: 12/6/23 12/10/23-refused 12/21/23 1/10/24 1/17/24 1/21/24 1/24/24 1/31/24 3. The record for Resident D was reviewed on 2/1/24 at 9:13	areas or wounds and ensure documentation in chart is accurate and current. 3. What measures will be put into place or what systematic changes the facility will ensure that the deficient practice does not occur? DON will create a new checklist To ensure there is proper Documentation for all residents who are given a shower and for when they refuse. Nurses will be reeducated on properly Documenting for wounds including Physician orders, home health notes, and follow up. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur, what quality assurance programs in place? DON or designee will review shower checklist 2 times weekly for the next 6 weeks to ensure all residents needing assistance
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a.m. Diagnoses included, but were not limited to history of stroke, left sided weakness and depression.

A Progress Note, dated 1/15/24, indicated the resident had an open area on his right gluteal fold that measured 2 centimeters (cm) x 2 cm. The Nurse Practitioner was notified and a treatment order was requested.

There was no Physician's order for contracted wound care or a treatment to the area.

There was no additional documentation of the open area, a referral to home health for treatment, ongoing monitoring, or any interventions or treatments implemented for the open area in the Progress Notes.

The January 2024 Physician Order Statement indicated to check for skin abnormalities every month and complete a Skin Observation form if any were noted.

During an interview with the ED, on 2/1/24 at 10:49 a.m., she indicated there was no additional documentation related to the open area.

A Service Plan, dated 7/1/23, indicated the resident required physical assistance for showers.

with showering are being given a shower/ offered a shower with proper documentation. DON or designee will review charts For residents with wounds/open areas Weekly for the next six weeks to ensure Follow up has been done and all documentation is in the resident's chart.

Once audits show

full compliance for 4 consecutive

weeks designee will stop audits.

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Shower sheets and shift reports for December 2023 and January 2024 indicated showers were given only on the following dates:

12/3/23

12/10/23

12/14/23

12/17/23

1/11/24

1/14/24

1/18/24

1/28/24

During an interview with the Executive Director, on 2/1/24 at 12:10 p.m., she indicated all residents should receive a shower or bed bath two times a week. She indicated they needed a better system to keep track of bathing.

This citation relates to Complaint IN00421674.

Based on record review and interview, the facility failed to ensure dependent residents received the necessary ADL (activities of daily living) assistance, related to showers as scheduled, for 3 of 3 residents reviewed for ADL care. (Residents B, C and D)
The facility also failed to follow

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up for treatment of a new open area for 1 of 3 residents reviewed for skin conditions. (Resident D)

Findings include:

1. The record for Resident B was reviewed on 2/1/24 at 9:00 a.m. Diagnoses included, but were not limited to, spinal stenosis, heart disease and osteoarthritis.

A Service Plan, dated 1/24/24, indicated the resident required physical assistance for showers.

Shower sheets and shift reports for December 2023 and January 2024 indicated showers were given only on the following dates:

12/2/23-refused

12/5/23

12/9/23

12/12/23-refused

12/19/23

1/14/24

1/16/24-refused

1/27/24

2. The record for Resident C was reviewed on 2/1/24 at 9:36 a.m. Diagnoses included, but were not limited to, mild

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cognitive impairment and
diabetes mellitus.

A Service Plan, dated 8/27/23,
indicated the resident needed
assistance with bathing.

Shower sheets and shift reports
for December 2023 and January
2024 indicated showers were
given only on the following
dates:

12/6/23

12/10/23-refused

12/21/23

1/10/24

1/17/24

1/21/24

1/24/24

1/31/24

3. The record for Resident D
was reviewed on 2/1/24 at 9:13
a.m. Diagnoses included, but
were not limited to history of
stroke, left sided weakness and
depression.

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	A Progress Note, dated 1/15/24, indicated the resident had an open area on his right gluteal fold that measured 2 centimeters (cm) x 2 cm. The Nurse Practitioner was notified and a treatment order was requested. There was no Physician's order for contracted wound care or a treatment to the area. There was no additional documentation of the open area, a referral to home health for treatment, ongoing monitoring, or any interventions or treatments implemented for the open area in the Progress Notes. The January 2024 Physician Order Statement indicated to check for skin abnormalities every month and complete a Skin Observation form if any were noted. During an interview with the ED, on 2/1/24 at 10:49 a.m., she indicated there was no additional documentation related to the open area. A Service Plan, dated 7/1/23, indicated the resident required physical assistance for showers.			
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	Shower sheets and shift reports for December 2023 and January 2024 indicated showers were given only on the following dates: 12/3/23 12/10/23 12/14/23 12/17/23 1/11/24 1/14/24 1/18/24 1/28/24 During an interview with the Executive Director, on 2/1/24 at 12:10 p.m., she indicated all residents should receive a shower or bed bath two times a week. She indicated they needed a better system to keep track of bathing. This citation relates to Complaint IN00421674.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (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	R 0349	1.What corrective actions will be accomplished for those residents found to have been affected by deficient practice?	03/01/2024

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OMB NO. 0938-0391

must be as follows:

- (1) Complete.
- (2) Accurately documented.
- (3) Readily accessible.
- (4) Systematically organized.

Based on record review and interview, the facility failed to ensure clinical records were accurate and complete related to lack of documentation of a pressure area and an open area, for 1 of 3 residents reviewed for skin concerns. (Resident C)

Finding includes:

Resident C's record was reviewed on 2/1/24 at 9:36 a.m. Diagnoses included, but were not limited to, mild cognitive impairment and diabetes mellitus.

A Progress Note, dated 12/30/23, indicated there were 3 pressure areas on the residents buttocks and a wound care evaluation and treatment was requested. There were no measurements or wound description noted.

A Progress Note, dated 1/3/24, indicated the home health nurse had visited for wound care and the wound was nearly resolved.

There were no home health

The resident with lack of documentation In chart about pressure wounds will have Chart updated with current condition, skin Assessment, and follow up wound care notes.

2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? DON or designee will review all residents with open areas or wounds and ensure documentation in chart is accurate and current.

3. What measures will be put into place or what systematic changes the facility will ensure that the deficient practice does not occur? Nurses will be reeducated on properly Documenting for wounds including Physician orders, home health notes, and follow up.

4. How will the corrective

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notes in the record for review.
There was no treatment order for the pressure areas, or indication how often the home health nurse visited.

The January 2024 Physician Order Statement indicated to check for skin abnormalities every month and complete a Skin Observation form if any were noted.

During an interview with the Executive Director (ED) and RN 1 on 2/1/24 at 10:38 a.m., the RN indicated a skin assessment was completed on 1/11/24 and no skin issues were noted. There was not a Skin Observation form completed when the pressure areas were initially found on 12/30/23. The ED indicated the home health nurse would e-mail her visit reports to the Director of Nursing, and she indicated the reports should be in the record.

When the Home Health Notes were received and reviewed, it was noted the wounds were not healed until 1/30/24.

This citation relates to Complaint IN00421674.

Based on record review and interview, the facility failed to ensure clinical records were accurate and complete related to lack of documentation of a pressure area and an open area, for 1 of 3 residents

actions
be monitored to ensure the deficient practice will not recur,
what quality assurance programs in place?
DON or designee will audit charts For residents with wounds/open areas Weekly for the next six weeks to ensure Follow up has been done and all documentation is in the resident's chart.

Once audits shows

full compliance for 4 consecutive

weeks designee will stop audits.

reviewed for skin concerns.
(Resident C)

Finding includes:

Resident C's record was reviewed on 2/1/24 at 9:36 a.m. Diagnoses included, but were not limited to, mild cognitive impairment and diabetes mellitus.

A Progress Note, dated 12/30/23, indicated there were 3 pressure areas on the residents buttocks and a wound care evaluation and treatment was requested. There were no measurements or wound description noted.

A Progress Note, dated 1/3/24, indicated the home health nurse had visited for wound care and the wound was nearly resolved.

There were no home health notes in the record for review. There was no treatment order for the pressure areas, or indication how often the home health nurse visited.

The January 2024 Physician Order Statement indicated to check for skin abnormalities every month and complete a Skin Observation form if any were noted.

During an interview with the Executive Director (ED) and RN 1 on 2/1/24 at 10:38 a.m., the RN indicated a skin assessment

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was completed on 1/11/24 and no skin issues were noted. There was not a Skin Observation form completed when the pressure areas were initially found on 12/30/23. The ED indicated the home health nurse would e-mail her visit reports to the Director of Nursing, and she indicated the reports should be in the record.

When the Home Health Notes were received and reviewed, it was noted the wounds were not healed until 1/30/24.

This citation relates to Complaint IN00421674.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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

TITLE

(X6) DATE