STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RITTENHOUSE VILLAGE AT VALPARAISO	1300 VALE PARK RD VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: August 31 and September 1, 2021. Facility number: 012181 Residential Census: 81 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 9/7/21.	R 0000	Rittenhouse Village at 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 laws.	
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview, and record review, the facility failed to maintain the safety of residents related to potential chemical hazards for	R 0148	1. What corrective actions will be accomplished for those residents found to have been affected by	10/01/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RITTENHOUSE VILLAGE AT VALPARAISO	1300 VALE PARK RD VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	2 of 17 residents who have dementia residing in the Memory Care Unit. (Resident 12 and Resident 14) Finding includes: During the Environmental Tour on 8/31/21 at 2:44 p.m. with the Maintenance Director, Director of Housekeeping and the Executive Director on the Memory Care locked unit, an open box half full of denture cleanser tablets and a 4 ounce bottle of Hibiclens chlorhexidine gluconate solution (an antiseptic skin cleanser) was observed on the bathroom counter in Room 317. On the denture cleanser tablet box and the Hibiclens cleanser bottle, indicated to call Poison Control if ingested or swallowed. Interview with the Executive Director at that time, indicated Resident 14 was more confused and than Resident 12 and the two items should not have been stored in the bathroom. Resident 12's record was reviewed on 9/1/21 at 10:54 a.m. Diagnoses included, but were not limited to, chronic kidney disease, diabetes mellitus and Chronic Obstructive Pulmonary Disease. The resident's latest Service Plan, dated 7/14/21, indicated the resident was alert and forgetful. Resident 14's record was reviewed on 9/1/21 at 10:56 a.m. Diagnoses included, but were not limited to, Alzheimer's Disease. The latest Service Plan, dated 6/28/21, indicated the resident was alert, confused and unable to communicate their needs.		deficient practice? • All hazardous items have been removed from apt of residents 12 and 14 (they are a married couple and share an apt) 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 that reside on MC have the potential to be affected • all MC apts have been checked for hazardous items and any found have been removed 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? • SLC and ED will educate all new families and residents at the time of move in regarding proper storage of hazardous material • MCD or designee will check the resident apts on MC weekly to look for any hazardous items and remove them as necessary • ED will in-service team members regarding proper storage of potentially hazardous items on 9/24/2021 4. How the corrective actions will be monitored to ensure that the deficient practice will not recur i.e, what quality assurance program will be put in place?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RITTENHOUSE VILLAGE AT VALPARAISO	1300 VALE PARK RD VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	A policy titled, "Medication Storage In The Facility," was provided by the Executive Director on 9/1/21 at 9:30 a.m. This current policy indicated, "1. Storage of Medications...e. Potentially harmful substances...are stored in a locked area...."		• ED will audit MC weekly rounds and will bring results of rounds to monthly QA	
R 0154 Bldg. 00	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. Based on observation and interview, the facility failed to maintain a clean and sanitary environment in the kitchen for 1 of 1 kitchens observed. (The Main Kitchen) This had the potential to affect all 81 residents who received food from the kitchen. Findings include: On 8/31/21 at 9:38 a.m., the kitchen's dishes lower shelves, plate warmer, the dishwasher shelves and the top of the dishwasher were observed to have debris and dried food . The double oven and oven were observed to have blackened and dried food debris on the bottom of the ovens. Interview with Culinary Director, on 8/31/21 at 9:48 a.m., indicated he did not have an answer, the kitchen should have been cleaner.	R 0154	1. What corrective actions will be accomplished for those residents found to have been affected by deficient practice? • All residents have the potential to be affected • Lower shelf where dishes are stored was cleaned 9/1 and is now free from debris and dried food • The plate warmer was cleaned on 9/1 and is now free from debris and dried food • The dishwasher shelves and the top of the dishwasher were cleaned on 9/1 and are now free from debris and dried food • The double oven and oven were cleaned on 9/1 and are now free from food debris 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	10/01/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RITTENHOUSE VILLAGE AT VALPARAISO	1300 VALE PARK RD VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			to be affected • ED and CSM will make thorough rounds in kitchen to identify any other areas that have debris/food build up and areas will be immediately cleaned 3. What measures will be put in to place or what systemic changes the facility will make to ensure that the deficient practice does not recur? • CSM will in-service all Culinary staff regarding the cleaning schedule on 09/28/2021 • CSM will have each TM responsible for the cleaning schedule sign that it is complete • CSM will review cleaning schedules daily for compliance 4. How the corrective actions will be monitored to ensure the deficient practive will not recur, ie, what quality assurance program will be put in place? • CSM will perform environmental rounds in the CSD daily x 30 days, if 100% compliance rounds will be reduced to weekly x 4 then monthly • ED will review all cleaning schedules • CSM will bring results of cleaning schedule audits to monthly QA	
R 0273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RITTENHOUSE VILLAGE AT VALPARAISO	1300 VALE PARK RD VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
Bldg. 00	(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 food was stored under safe and sanitary conditions related to unlabeled and not dated after open for beverages and foods, expired thickened liquids and a cook not using a hairnet in the main kitchen. (Main Kitchen) This had the potential to affect 81 resident who resided in the facility and were served food from the main kitchen. Findings include: 1. During the initial kitchen tour on 8/31/21 at 9:38 a.m., the following was observed: a. The "Juice Refrigerator," had 6 beverages covered, in pitchers, unlabeled and undated. Interview with the Culinary Director at that time indicated the kitchen staff was in a hurry and did not label the pitchers. The beverages in the refrigerator also go the the Memory Care Unit residents' dining room. b. In the cooler, a cart with individual dishes of yogurt, cottage cheese and applesauce were not fully covered and not dated. There was one plastic cover with holes in it that covered part of the food cart. Interview at that time with the Culinary Director, indicated foods are prepped each morning and then the left overs are to be discarded at the end of each day. c. In the dry storage area, many thickened liquids were observed to be expired: - 6 containers of Orange Juice, use by date of	R 0273	1. What corrective actions will be accomplished for those residents found to have been affected by deficient practice? • All residents have the potential to be affected • All food and beverages reviewed and date open labels added • Expired thickened liquids were disposed of • Cook donned a hair net 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? • CSD and ED will perform rounds in kitchen to identify any other areas of deficiency any areas of concern will be immediately rectified 3. What measures will be put in to place or what systemic changes the facility will make to ensure that the deficient practice does not occur? • CSM will in-service all Culinary staff regarding hair net use and proper labeling/dating of all food/beverages 09/28/2021 • CSM will spot check all storage areas daily x 30 days to make sure that all items are properly labeled/dated and if 100% compliance will change to weekly	10/01/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RITTENHOUSE VILLAGE AT VALPARAISO	1300 VALE PARK RD VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	5/25/21 - 2 containers of Orange Juice, use by date of 3/30/21 - 6 containers of Prune Juice, use by date of 7/11/21 - 4 containers of Apple Juice, use by date of 3/3/21 - 3 containers of Lemon flavored water, use by date of 5/12/21 - 2 containers of Lemon flavored water, use by date of 3/3/21 - 2 containers of Lemon flavored water, use by date of 3/29/21 d. In the food prep area, a large container of a sugary substance was unlabeled and undated. Interview with the Culinary Director at that time, indicated the container was brown sugar and the label had come off. A policy titled, " Dietary Leftovers, " was provided by the Culinary Director on 8/31/21 at 2:33 p.m. This current policy indicated, "...Procedure:...6. Label pan with contents, date, and time placed in refrigerator...." 2. During the lunch service observation on 8/31/21 at 11:56 a.m., Cook 1 indicated he was making a gravy for tonight's dinner. Cook 1 had hair longer than a quarter inch and was without a hairnet. Interview at that time with Cook 1 indicated his hair was short enough and did not need a hairnet. Interview with the Culinary Director on 8/31/21 at 1:15 p.m., indicated Cook 1 usually shaved his head, and his hair was over a quarter inch long and he needed to wear a hairnet. A policy titled, "Dietary Personal Hygiene," was		x 4 • CSM will make sure that all cooks have their hair net in place 4. How corrective actions will be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put in place • CSM will spot check all storage areas daily x 30 days to make sure that all items are properly labeled/dated and if 100% compliance will change to weekly x 4 • CSM will make sure that all cooks have their hair net in place-any cook that does not have hair net in place will be subject to 1:1 reinstruction • Results of kitchen audits will be reviewed in monthly QA meeting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RITTENHOUSE VILLAGE AT VALPARAISO	1300 VALE PARK RD VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	provided by the Culinary Director on 8/31/21 at 1:35 p.m. This current policy indicated, "...Head coverings:...4. Men must also wear hair coverings...."			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (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. Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to a Tuberculosis (TB) blood test and a resident's Vitamin D not ordered in a timely manner for 1 of 7 records reviewed. (Resident 3) Finding includes: Resident 3's record was reviewed on 8/31/21 at 10:42 a.m. Diagnoses were included, but limited to, diabetes mellitus. Admission/move in date was on 8/26/21. A Nurse Progress Note, dated 8/26/21 at 5:45, (no indication of a.m. or p.m.) indicated a TB skin test was "placed in his left forearm". The Medication Administration Record, dated 8/28/21, indicated the TB skin test was read. The record lacked the results of the TB skin test.	R 0349	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? • Resident #3 TB test read and documented • Resident #3 vitamin ordered and on hand-resident is receiving medication as ordered 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 • All current resident medical records will be audited regarding correct documentation of TB tests • All current resident medications orders will be audited to assure that all ordered medications are available	10/01/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RITTENHOUSE VILLAGE AT VALPARAISO	1300 VALE PARK RD VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Interview with the Assistant Health and Wellness Director, on 8/31/21 at 1:45 p.m., indicated the Agency Nurse should have documented the results in the resident's chart. Interview with Executive Director, on 9/1/21 at 10:38 a.m., indicated the facility did not have a policy on where to document a TB result. The current Physician's Order Summary indicated the resident was to receive Vitamin D 2,000 IU (International Unit) 1 tablet by mouth daily. The Medication Administration Record for Vitamin D 2, 000 IU, had nurses' initials circled on the following dates: 8/27, 8/28, 8/29, 8/30 and 8/31. A "Pharmacy Policy," dated 7/12/21, indicated the resident authorized the facility to order his medication through the two pharmacies listed on the form. Interview with the Assistant Health and Wellness Director on 8/31/21 at 11:35 a.m., indicated the nurses' initials that were circled meant the nurse did not given the Vitamin. The family did not bring the Vitamin, and she indicated after 3 days the facility should have ordered the Vitamin from the facility's pharmacy. A policy titled, "Assisted Living Resident Care Policies and Procedures 8.0 Medications Provided by Pharmacy," was provided by the Assistant Health and Wellness Director on 8/31/21 at 11:50 a.m. This current policy indicated, "...Process...If a resident does not have their medication available at the time of administration a one to seven day supply will be ordered from (name of pharmacy) pharmacy...."		• Any deficient practice noted during the audits will be rectified 3. What measures will be put in to place or what systemic changes the facility will make to ensure that the deficient practice does not recur • All licensed nurses will be in-serviced regarding TB documentation policy and medication availability policy on 09/24/2021 4. How the corrective actions will be monitored to ensure the deficient practice does not recur, ie, what quality assurance program will be put in place? • DHW or designee will audit clinical records of residents with TB tests administered and medications not given due to not being available weekly. • DHW or designee will report results of audits at monthly at QA.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RITTENHOUSE VILLAGE AT VALPARAISO	1300 VALE PARK RD VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
R 0407 Bldg. 00	. 410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, interview, and record review, the facility failed to ensure infection control guidelines were in place and implemented, including those specific to properly prevent and/or contain COVID-19, related to an unvaccinated staff member not wearing appropriate eye covering during resident care and residents not wearing masks when they were not socially distanced. (QMA 1) Findings include: 1. On 8/31/21 at 9:30 a.m., QMA 1 was observed administering eye drops to a resident. The QMA was wearing a surgical mask and no eye protection. Interview with QMA 1 on 8/31/21 at 9:50 a.m., indicated she was not vaccinated for COVID-19.	R 0407	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? • QMA 1 was counseled on the face mask/face shield guidelines • Residents were asked to put on their masks 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 by the deficient practice	10/01/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RITTENHOUSE VILLAGE AT VALPARAISO	1300 VALE PARK RD VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	She was unaware she had to wear eye protection when she provided direct resident care. The CDC (Centers for Disease Control and Prevention) COVID Data Tracker indicated that on 8/31/21, the Porter County positivity rate was high at 11.13%. 2. On 8/31/21 at 10:00 a.m., multiple residents were observed sitting at a couple tables conversing with one another and playing a game. The residents were not 6 feet apart from one another and none of them were wearing masks. A staff member was observed by the residents during the activity. The staff member did not ask any of the residents to put on a mask. On 8/31/21 at 12:00 p.m., approximately 40 residents were observed sitting in the dining room waiting for lunch. Multiple residents were at each table. They were not 6 feet apart from each other and none of them were wearing masks. Multiple staff were observed taking the resident's lunch orders. No staff were observed to ask the residents to put on a mask. On 8/31/21 at 1:32 p.m., multiple residents were observed sitting at 3 tables conversing with one another and playing a game. The residents were not 6 feet apart from one another and none of them were wearing masks. Three staff members were observed by the residents during the activity. The staff members did not ask any of the residents to put on a mask. Interview with the Administrator on 8/31/21 at 1:34 p.m., indicated the residents have been asked to wear a mask and they have all refused to wear them.		3. What measures will be put in to place or what systemic changes the facility will make to ensure that the deficient practice does not recur • All staff are being in-serviced on face mask/ face shield guidelines on 09/24/2021 4. How the corrective actions will be monitored to ensure the deficient practice does not recur, ie, what quality assurance program will be put in place? • DHW or designee will make rounds daily ensuring face shields are in place for unvaccinated staff when county positivity rates are over 5% and providing direct care within 6 feet of resident • ED or designee will make rounds daily ensuring staff a reminding are residents of the use of face masks • Results of audits will be reviewed at Monthly QA	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RITTENHOUSE VILLAGE AT VALPARAISO	1300 VALE PARK RD VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	The Indiana Department of Health COVID-19 Long Term Care (LTC) Infection Control Guidance Standard Operating Procedure, updated 8/11/21, indicated, "... Unvaccinated HCP (healthcare personal) must wear face mask (medical) and eye protection with face shield /or goggles as a standard safety measure to protect LTC HCP (SNF/AL) who provide essential direct care within 6 feet of the resident, regardless of COVID-19 status, when there is moderate to substantial (high) community transmission..." "...IF the county positivity rates are > 5% with increase to moderate or high substantial community transmission then eye protection should be used by unvaccinated HCP for all residents within 6 feet when delivering essential direct care regardless of COVID 19 status....." The Indiana Department of Health Adjunct IDOH Guidance: LTC Facilities Guidelines in Response to COVID-19 Vaccination, updated 7/29/21, indicated, "...This will directly impact all visitors, healthcare personnel and residents at LTC, skilled nursing facilities and assisted living facilities. Masks are required for all when the county positivity rates are above 5% per Indiana Department of Health (IDOH) current guidance and risk assessments...." "...Fully vaccinated residents should wear a mask during all indoor activities, including church services, going on excursions when county positivity rates are equal to or above 5%. Fully vaccinated residents and fully vaccinated visitors are required to wear masks when indoors when the county positivity rates are equal to or above 5%...."			
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RITTENHOUSE VILLAGE AT VALPARAISO	1300 VALE PARK RD VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.			
	Based on record review and interview, the facility failed to ensure an annual Tuberculosis (TB) test was completed for 1 of 7 residents whose records were reviewed. (Residents 6) Finding includes: Resident 6's record was reviewed on 9/1/21 at 9:48 a.m. Diagnoses included, but were not limited to, end stage renal disease, and high blood pressure. The record lacked an indication of a current annual TB test. The last TB test was completed on 8/28/2020. Interview with the Health and Wellness Director on 9/1/21 at 10:15 a.m., indicated her annual Tuberculin test was missed. A policy for the tuberculin skin test was	R 0410	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? • Resident 6 had her TB test completed on 09/01/2021 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 by the deficient practice • DHW or designee will audit all current resident clinical records to ensure TB tests are in compliance	10/01/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RITTENHOUSE VILLAGE AT VALPARAISO	1300 VALE PARK RD VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	requested and none received by the end of the survey.		3. What measures will be put in to place or what systemic changes the facility will make to ensure that the deficient practice does not recur • All licensed nurses are being in-serviced on TB test administration on 09/24/2021 4. How the corrective actions will be monitored to ensure the deficient practice does not recur, ie, what quality assurance program will be put in place? • DHW or designee will audit clinical records for TB test compliance Monthly • Results of audits will be reviewed at Monthly QA	