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	04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RITTENHOUSE VILLAGE AT PORTAGE	6235 STERLING CREEK RD PORTAGE, IN 46368

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00407163 and IN00407214. Complaint IN00407163 - State deficiencies related to the allegations are cited at R0268 and R0406. Complaint IN00407214 - State deficiencies related to the allegation are cited at R0406. Survey date: April 27, 2023. Facility number: 012396 Residential Census: 79 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 5/3/23.	R 0000	The following is the plan of correction for the Rittenhouse Village at Portage in regards to the statement of deficiencies dated April 27th, 2023. 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.	
R 0268 Bldg. 00	410 IAC 16.2-5-5.1(a) Food and Nutritional Services - Deficiency (a) The facility shall provide, arrange, or make available three (3) well-planned meals a day, seven (7) days a week that provide a balanced distribution of the daily nutritional requirements. Based on observation, record review and interview, the facility failed to ensure meals were	R 0268	1.What corrective actions will be accomplished for those residents	05/31/2023

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

Kristin Pawlak | Executive Director | 05/26/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	provided to a resident in COVID-19 isolation for 1 of 3 residents reviewed. (Resident C) Finding includes: Interview with Resident C on 4/27/23 at 10:40 a.m., indicated she had tested positive for COVID-19 on 4/17/23 and has had to stay in her room since then on isolation. Since she had been in isolation, she hadn't received some of her meals. Staff was supposed to come take her order for each meal and then deliver the food to her room after service in the Main Dining Room. No one had come to ask for her breakfast order this morning and she had not received any food. There was no breakfast tray observed in her room. Interview with CNA 1 on 4/27/23 at 10:50 a.m., indicated she would go speak with the resident. She was unsure why she wouldn't have received breakfast. On 4/27/23 at 10:57 a.m., a staff member was observed taking the resident's lunch order. Follow up interview with Resident C on 4/27/23 at 12:40 p.m., indicated staff had finally come to speak to her around 11 a.m. regarding her breakfast but she felt it was too late so she decided to just wait for her lunch. She had just received her lunch tray and was going to eat. The record for Resident C was reviewed on 4/27/23 at 9:08 a.m. Diagnoses included, but were not limited to, anxiety and depression. A Service Plan, dated 1/23/23, indicated the resident was cognitively intact, received a regular diet, and was independent with dining.		found to have been affected by deficient practice? Residents will be notified of meal times and room tray delivery times. In addition, nursing staff will have a checklist documenting resident was asked/received meals. 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? All residents have the potential to be effected. All staff in serviced on meal times and ensuring checklist is used to document resident received meal. 3. What measures will be put into place or what systematic changes the facility will ensure that the deficient practice does not occur? Checklist for meal times is implemented and used to ensure deficient practice does not occur.	

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	Interview with the Director of Nursing (DON) on 4/27/23 at 1:00 p.m., indicated staff had told her the resident refused breakfast this morning but she was unable to provide any documentation. This state residential finding relates to complaint IN00407163.		How will the corrective actions be monitored to ensure the deficient practice will not recur, what quality assurance programs in place? Director of Nursing or designee will audit checklist by asking 3 residents daily for a minimum of 6 weeks if meal was received. Once audits show full compliance for 4 consecutive weeks designee will stop audits. However, the checklist will remain to be able to do random audits and for documentation.	
R 0406 Bldg. 00	410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to improper personal protective equipment (PPE) worn in an isolation room (LPN 1), lack of monitoring residents with COVID-19 (Residents B, C and D), lack of a policy related to monitoring residents with COVID-19, and not disinfecting community materials after activities during a COVID-19 outbreak. This had the potential to affect all 79 residents in the facility.	R 0406	1.What corrective actions will be accomplished for those residents found to have been affected by deficient practice? Respiratory assessment and vitals will continue to be done and documented In the M.A.R. All staff to be re inserviced on Infection control policy, PPE policy, and handwashing policy. Inservices will remain in place annually.	05/31/2023

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	Findings include: 1. On 4/27/23 at 8:10 a.m., LPN 1 was observed passing medications. She indicated the resident was on isolation for COVID-19. As she prepared to enter the room, she donned an isolation gown, applied an N-95 respirator over the surgical mask she was wearing, and donned gloves, and entered the room without donning any eye protection. Upon exiting the room, she had removed all PPE except the surgical mask she continued to wear. The signage posted on the resident's door indicated the resident was on droplet precautions. PPE required to enter room was an isolation gown, an N-95 respirator, gloves and eye protection. Interview with the Director of Nursing (DON), on 4/27/23 at 8:55 a.m., indicated the LPN should have donned a gown, gloves, N-95 and eye protection, and not applied an N-95 over a surgical mask. 2. Resident D's record was reviewed on 4/27/22 at 9:22 a.m. Diagnoses included, but were not limited to, left sided weakness following a CVA and chronic obstructive pulmonary disease. On 4/15/23, the resident had confusion and a cough. She tested positive for COVID-19. On 4/16/23, the resident had increased confusion and worsening symptoms, she was sent to the hospital and admitted. She returned to the facility on 4/21/23. The Nursing Readmission Note, on 4/21/23, indicated the resident was still COVID-19 positive. There were no vitals signs or a respiratory assessment documented.		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? All residents have the potential to be effected. Respiratory assessment and vitals will be done and documented in the M.A.R. Infection control policy, PPE policy, and handwashing policy In-serviced to all staff and monitored for compliance. 3. What measures will be put into place or what systematic changes the facility will ensure that the deficient practice does not occur? Staff will be reeducated on infection control policy, PPE policy, and handwashing policy and inservicing will continue annually, or more often as needed. The M.A.R is where respiratory Assessment and vitals will be documented for COVID positive resident.	

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	A Nursing Note on 4/22/23 noted a temperature. A Nursing note on 4/23/23 lacked a respiratory assessment and vitals. here were no Nursing notes entered for 4/24 and 4/25/23. On 4/26/23 the resident was taken off isolation. Interview with the DON, on 4/27/23 at 8:55 a.m., indicated residents who were COVID-19 positive should be monitored every shift for worsening symptoms, temperature, and oxygen saturation. 3. Interview with Resident C on 4/27/23 at 10:40 a.m., indicated she had tested positive for COVID-19 on 4/17/23 and has had to stay in her room since then on isolation. Since she had been in isolation, she hadn't been assessed by a Nurse and no one had checked her vital signs. The record for Resident C was reviewed on 4/27/23 at 9:08 a.m. Diagnoses included, but were not limited to, anxiety and depression. A Service Plan, dated 1/23/23, indicated the resident was cognitively intact. A Progress Note, dated 4/17/23, indicated the resident had tested positive for COVID-19. A Progress Note, dated 4/22/23, indicated the resident was asymptomatic and had no complaints. There was a lack of documentation of any other COVID-19 monitoring or assessment of vital signs for the resident while positive for COVID-19. Interview with RN 1 on 4/27/23 at 9:45 a.m., indicated she would check on her COVID positive		How will the corrective actions be monitored to ensure the deficient practice will not recur, what quality assurance programs in place? Director of Nursing or designee will audit 5 team members a week on handwashing/PPE requirements for 6 weeks. Once audits show full compliance for 4 consecutive weeks designee will stop audits. Audits will continue during outbreaks to control the spread of infections. Director of Nursing or designee will monitor covid positive residents in the next 6 weeks by auditing respiratory assessment 2 times a week for the remainder of the outbreak if applicable.	

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	residents once a shift but there was no specific area any assessments or vital signs were to be documented. Some staff would document on the 24 hour report sheets. 4. The record for Resident B was reviewed on 4/27/23 at 11:06 a.m. Diagnoses included, but were not limited to, hypertension and diabetes mellitus. A Progress Note, dated 4/17/23, indicated the resident had tested positive for COVID-19. A Progress Note, dated 4/22/23, indicated the resident was afebrile and had no symptoms. A Progress Note, dated 4/25/23, indicated the resident remained in isolation and had no complaints. There was a lack of documentation of any other COVID-19 monitoring or assessment of vital signs for the resident while positive for COVID-19. Interview with RN 1 on 4/27/23 at 9:45 a.m., indicated she would check on her COVID positive residents once a shift but there was no specific area any assessments or vital signs were to be documented. Some staff would document on the 24 hour report sheets. 5. The current policy, "COVID-19 Policy-Outbreak", was reviewed on 4/27/23. The policy lacked guidelines for monitoring residents with COVID-19. Interview with the DON, on 4/27/23 at 11:12 a.m., indicated she would update the policy to include the monitoring guidelines. 6. On 4/27/23 at 10:29 a.m., the Activity Director			

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	was observed seated with three residents at a table playing dice. The current policy, "Communicable Disease", indicated, "...All hard surface areas must be disinfected with approved disinfectants that are effective against the infection or disease...." Interview with the Activity Director, on 4/27/23 at 11:30 a.m., indicated she would normally wash activity items, such as dice, with hot soapy water after use but she had not done so today. She was not aware of the need to use proper disinfectant supplies. Interview with the DON, on 4/27/23 at 11:49 a.m., indicated soap and water was not the best choice for COVID-19 and items should be disinfected with the proper cleaning supplies. This state residential finding relates to Complaints IN00407163 and IN00407214.			