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

FORM APPROVED
OMB NO. 0938-039

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	08/18/2023

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 a State Residential Licensure Survey. Survey dates: August 17 and 18, 2023. Facility number: 012396 Residential Census: 89 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 8/22/23.	R 0000		
R 0030 Bldg. 00	410 IAC 16.2-5-1.2(e)(1-6) Residents' Rights - Noncompliance (e) Residents have the right to be provided, at the time of admission to the facility, the following: (1) A copy of his or her admission agreement. (2) A written notice of the facility ' s basic daily or monthly rates. (3) A written statement of all facility services (including those offered on an as needed basis). (4) Information on related charges, admission, readmission, and discharge policies of the facility. (5) The facility ' s policy on voluntary termination of the admission agreement by the resident, including the disposition of any entrance fees or deposits paid on admission. The admission agreement shall include at least those items provided for in IC 12-10-15-9. (6) If the facility is required to submit an			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Steffani Dranchak	RN,DON	09/17/2023

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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	Alzheimer ' s and dementia special care unit disclosure form under IC 12-10-5.5, a copy of the completed Alzheimer ' s and dementia special care unit disclosure form.			
	Based on record review and interview, the facility failed to have a current disclosure form for the Alzheimer's/Dementia Special Care Unit. Finding includes: The Alzheimer's/Dementia Special Care Unit disclosure form was requested on 8/17/23 at 11:00 a.m. and 2:55 p.m. Interview with the Director of Nursing on 8/17/23 at 2:55 p.m., indicated she was unsure what the Dementia Unit Disclosure Form was. The Administrator would probably know where it was but was out of the facility on leave. Interview with the Business Office Manager on 8/18/23 at 10:34 a.m., indicated they had been unable to locate the Dementia Unit Disclosure form.	R 0030	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The Alzheimer's/Dementia Special Care Unit disclosure form was completed online and printed on 8/31/2023. 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. 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; The Alzheimer's/Dementia Special Care Unit disclosure for was completed online, printed, and placed in the New Move In packets. All department managers were inserviced on the form on 9/1/23. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The form will be completed annually by the ED and will be reviewed by the RDO as part of ongoing Quality Assurance.	09/01/2023

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			5. By what date the systemic changes will be completed. Systemic changes will be completed by 9-1-23	
R 0092 Bldg. 00	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 emergency as follows: (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. (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.			
	Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift, staff present at the fire drills were documented, and the local fire department was invited to participate at least every 6 months. This had the potential to affect all 89 residents residing in the facility.	R 0092	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Fire drill was conducted on 9/1/23. The fire department was contacted on 9/1/23 and will be onsite to watch a fire drill on	09/01/2023

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	Finding includes: The fire drill book was provided for review on 8/17/23 at 10:30 a.m. Fire drills were completed on 2/2/23 on the first, second and third shift, on 10/28/23 second and third shift, and 10/29/23 first shift. There was no documentation or signatures of the employees who participated in the fire drills. There were no additional fire drills for the past twelve months. There was no documentation the local fire department had been invited to participate in any of the fire drills. Interview with the Maintenance Director at that time, indicated he had taken over the position about nine months ago. He had not completed any fire drills since he took the position. He was also not aware the local fire department needed to be invited every six months to participate.		10/10/23. 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. 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; Maintenance Director was educated on fire drill procedures on 8/29/23. Maintenance Director will upload completed fire drills with signatures into TELS system, as well as keep the physical copies in a binder onsite. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; At monthly QA meeting, fire drill reports will be reviewed for compliance on an ongoing basis indefinitely. 5. By what date the systemic changes will be completed. Completion date 1/1/2024	
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have			

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	a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review and interview, the facility failed to ensure background checks were completed using the Indiana State Police (ISP) Repository prior to starting employment, for 2 of 5 employee records reviewed. (CNA 1 and LPN 1) Findings include: The employee records were reviewed on 8/18/23 at 10:00 a.m. a. CNA 1 was hired on 5/25/23. A statewide criminal court search was completed on 5/27/23 by a background check company. There was lack of documentation the company had utilized the ISP Repository to complete the background check. b. LPN 1 was hired on 6/23/23. A statewide criminal court search was completed on 6/14/23 by a background check company. There was lack of documentation the company had utilized the ISP Repository to complete the background check. Interview with the Business Office Manager on 8/18/23 at 12:19 p.m., indicated she had spoken with the background check company and they had not used the ISP Repository to complete the background checks. The facility had to request a different background check package that included a check of the ISP Repository. The facility had requested this package on 7/18/23 but it had not been implemented yet.	R 0116	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; CNA 1's background check was run on 8/19/23 using the correct package that includes the ISP repository LPN 1 background check was run on 8/19/23 using the correct package that includes the ISP repository. 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; The BOM will audit all team member files to ensure all team members have the correct background check completed. Any team members files found to not be in compliance will be re-done with the correct background check. 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; BOM will work with 3rd party HR company to ensure correct background checks are being completed. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur,	09/01/2023

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			i.e., what quality assurance program will be put into place; BOM will audit all new hire background checks monthly to ensure compliance and report the findings at the montly QA indefinitely. 5. By what date the systemic changes will be completed. 11-1-2023	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.			
	Based on record review and interview, the facility failed to ensure there was one staff member with a	R 0117	1. What corrective action(s) will be accomplished for those residents	09/30/2023

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	current first aid certificate scheduled for 10 of 21 shifts reviewed. This had the potential to affect all 89 residents residing in the facility. Finding includes: Facility staffing schedules for 8/11/23 through 8/17/23 were reviewed on 8/18/23 at 10:00 a.m. The schedules indicated there were no staff members who were first aid certified on the following dates and shifts: Evening shift on 8/11/23, 8/15/23, and 8/16/23. Midnight shift on 8/11/23, 8/12/23, 8/13/23, 8/14/23, 8/15/23, 8/16/23, and 8/17/23. Interview with the Director of Nursing on 8/18/23 at 12:04 p.m., indicated all of the nurses had CPR certification but she was unaware first aid certification was required.		found to have been affected by the deficient practice All nurses and QMA's without current first aide certification will complete certification by 09/30/2023 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. 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; DON will complete a monthly audit to ensure at least 1 staff member on each shift has a current CPR and first aid certification. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Monthly audit results will be shared at monthly QA meeting. 5. By what date the systemic changes will be completed. 09/30/2023	
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:			

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	(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 record review and interview, the facility failed to ensure written policies were in place related to ensure maintenance was kept in safe, working conditions, and failed to have an annual inspection of the heating ventilation system (HVAC). This had the potential to affect all 89 residents residing in the facility. Finding includes: The Maintenance Binder was reviewed on 8/18/23. There were no written policies included in the binder that indicated how often fire alarms, generators, sprinklers or other mechanical systems needed to be inspected or have preventative maintenance. The last HVAC inspection was dated 10/25/19. Interview with the Maintenance Director, on 8/18/23 at 9:40 a.m., indicated the HVAC system had not been inspected. Interview with the Director of Nursing on 8/18/23 at 11:15 a.m., indicated she was unable to locate any maintenance policies.	R 0148	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The Maintenance Director was educated on TELS maintenance system by Regional Maintenace Director on 9/1/2023. 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 resident's have the potential to be affected. 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; Training of the Maintenance Director on 9/1/23 included to ensure written policies were in place related to ensure maintenance was kept in safe, working conditions, and to have an annual inspection of the heating	09/30/2023

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			ventilation system (HVAC). 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; At monthly QA meeting maintenance director will report on vendors in, work orders, and general conditions of the community. · By what date the systemic changes will be completed. 9/30/2023	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations			

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	subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure Service Plans were updated when a change occurred for 3 of 7 resident Service Plans reviewed. (Residents 4, 7 and 2) Findings include: 1. The record for Resident 4 was reviewed on 8/17/23 at 1:40 p.m. Diagnoses included, but were not limited to, vascular dementia, psychosis and major depression. The current Service Plan, dated 10/13/22, indicated the resident was on hospice, received a modified mechanical soft diet and had no falls. The Service Plan noted 2 falls on 4/11/23 and 5/16/23 on the signature page, however no changes were made in the plan of care. A Hospice Note indicated the resident was discharged from hospice on 2/19/23. Nursing Notes indicated the resident had a fall on 4/11/23 and 5/16/23. The resident's diet was changed from mechanical soft to regular on 12/9/23. There were no changes made to the Service Plan. Interview with the Director of Nursing on 8/17/23 at 2:58 p.m., indicated the Service Plan should have been updated when the changes occurred. 2. Record review for Resident 7 was competed on 8/17/23 at 11:46 a.m. Diagnoses included, but were not limited to, hypertension, depression, and dementia.	R 0217	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The service plan for resident 4 was updated 8/19/2023 to include Hospice discharge, modified diet, recent falls. The service plan for Resident 7 was updated 8/19/2023 to include Hospice Services. The service plan for Resident 2 was updated on 8/19/23 to include Hospice Services. 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. 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; DON will audit all residents to ensure service plans are accurate for current residents receiving services. DON or designee will audit 5 random service plans monthly for accuracy.	09/01/2023

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	A Service Plan was completed on 9/1/22 and signed by the resident's Power of Attorney (POA). The Service Plan had not included any contracted services. The resident was started on hospice services in April 2023. The record lacked any documentation a Service Plan was completed after the resident was started on hospice services. Interview with the Director of Nursing on 8/17/23 at 2:55 p.m., indicated a Service Plan should have been updated and completed when the resident went on hospice services and was not completed.3. Resident 2's record was reviewed on 8/17/23 at 1:16 p.m. Diagnoses included, but were not limited to, hypertension, atrial fibrillation, and generalized anxiety disorder. A Service Plan was completed on 1/23/23 and signed by the resident. The resident had started hospice services in July 2023. The record lacked any documentation a Service Plan was completed or updated after the resident was started on hospice services. Interview with the Director of Nursing on 8/17/23 at 2:55 p.m., indicated she had not updated the service plan to indicate the resident was receiving hospice services.		4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; ED will review audit tool for compliance weekly during morning meeting. 5. By what date the systemic changes will be completed. 9/1/23	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a			

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	PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.			
	Based on record review and interview, the facility failed to ensure a PRN (as needed) medication was administered upon authorization by a licensed nurse or physician for 1 of 7 residents reviewed. (Resident 2) Finding includes: Resident 2's record was reviewed on 8/17/23 at 1:16 p.m. Diagnoses included, but were not limited to, hypertension, atrial fibrillation, and generalized anxiety disorder. The Physician's Order Summary, dated 8/2023, indicated an order for tramadol (pain medication) 50 mg (milligrams) twice daily PRN, hydrocodone-acetaminophen (pain medication) 10-325 mg every 6 hours PRN, and guaifenesin syrup (cough syrup) 10 ml (milliliters) every 4 hours PRN. The Medication Administration Record (MAR), dated 8/2023, indicated the PRN tramadol was given by QMA 1 on 8/1/23, 8/4/23, and 8/5/23. The PRN hydrocodone-acetaminophen was given by QMA 1 on 8/9/23, 8/11/23, 8/16/23, and twice on 8/10/23. The PRN guaifenesin syrup was given by QMA 1 on 8/11/23 and twice on 8/10/23. There was a lack of documentation to indicate the QMA had received authorization from a licensed nurse prior to administering the medication. Interview with the Director of Nursing on 8/18/23 at 9:31 a.m., indicated the QMAs were supposed to get approval from the nurse prior to giving a	R 0246	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; QMA's in serviced on medication administration and PRN documentation on 8/21/2023. 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. 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; DHW will audit PRN administration record weekly to ensure proper notification was completed by QMA's. · How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; DON or designee will audit QMA nurse notification forms weekly to ensure continued compliance. 5. By what date the systemic changes will be completed. 9/1/23	09/01/2023

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	08/18/2023

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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	PRN medication. There was a PRN log they were supposed to fill out, but she was unable to provide any documentation QMA 1 had obtained approval prior to administering the PRN medications.			
R 0269 Bldg. 00	410 IAC 16.2-5-5.1(b) Food and Nutritional Services - Noncompliance (b) The menu or substitutions, or both, for all meals shall be approved by a registered dietician. Based on observation, record review, and interview, the facility failed to serve meals from a menu approved by a Registered Dietician (RD). This had the potential to affect all 89 residents residing in the facility and receiving meals. Finding includes: On 8/17/23 at 11:42 a.m., the Culinary Director was observed checking the lunch food temperatures. The lunch meal was chicken with dumplings, corn, green beans, carrots, and tomato soup. Interview with the Culinary Director on 8/17/23 at 11:42 a.m., indicated that he started in the position on 7/5/23 and had been making his own menus. He indicated he had not kept the menus that he prepared. The Registered Dietician (RD) had not approved the menus that he had served. A weekly menu, approved by the RD, was provided by the Culinary Director on 8/18/23. He indicated the new menu was to start on 8/12/23. Interview with the Director of Nursing (DON) on 8/17/23 at 1:00 p.m., indicated that they had the same RD for a while and she was not sure why there were not approved menus to follow.	R 0269	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; New menu that was reviewed and approved by RD was initiated on 8/21/2023. 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. 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; Kitchen Manager to have RD review proposed menus during RD monthly visit to facility. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; ED will ensure that menu has	08/21/2023

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		A. BUILDING 00 B. WING	08/18/2023

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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			been approved by RD during monthly QA meeting. · By what date the systemic changes will be completed. 1/1/2024	
R 0297 Bldg. 00	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana.			
	Based on record review and interview, the facility failed to ensure medications were available at all times for 1 of 7 resident records reviewed. (Resident 4) Finding includes: The record for Resident 4 was reviewed on 8/17/23 at 1:40 p.m. Diagnoses included, but were not limited to, vascular dementia, psychosis and major depression. A Physician's Order, dated 11/18/22, indicated to give Lorezepam, (anti-anxiety medication) 0.5 milligrams every night. The July 2023 Medication Administration Record indicated the medication was not given on July 13, 14, 15, 16 and 17 due to "not available." Notes indicated "awaiting delivery from pharmacy." Interview with the Director of Nursing, on 8/18/23 at 9:46 a.m., indicated the pharmacy claimed they had not received the prescription from the Physician on 7/14/23. On 7/17/23, the Physician	R 0297	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; DON inserviced all nurse's QMA's on medication management to include ordering medications in enough time so that medications do not run out on 8/31/2023. 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. 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; DON or designee to audit 5 random MAR's weekly x 8 weeks to ensure that all medications for all residents are in facility and	09/30/2023

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		A. BUILDING 00 B. WING	08/18/2023

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RITTENHOUSE VILLAGE AT PORTAGE	6235 STERLING CREEK RD PORTAGE, IN 46368

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	sent the prescription again and the medication was sent out at that time.		being administered correctly. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; DON or designee will continue to audit MARs during monthly chart reviews. 5. By what date the systemic changes will be completed. 9/30/2023	