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	10/10/2024

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: October 9 and 10, 2024 Facility number: 012396 Residential Census: 80 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 10/15/24.	R 0000		
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency Based on record review and interview, the facility failed to promptly notify the resident's physician of a significant change in status related to a fall with injury for 1 of 7 residents reviewed. (Resident 3) Finding includes: The record for Resident 3 was reviewed on 10/9/24 at 1:37 p.m. Diagnoses included, but were not limited to Parkinson's disease, acute kidney failure, and high blood pressure. A Service Plan, dated 10/7/24, indicated the resident was cognitively intact for daily decision making and had a history of falls. Nursing Progress Notes, dated 5/2/24 at 5:00 a.m., indicated the resident was found on the floor in his room. The resident indicated he was walking,	R 0036	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? DON will audit all residents who have had a fall within the last 30 days to ensure physician was notified and to ensure proper documentation. 2. How 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. Audit for falls will	11/01/2024

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

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	started having tremors, began to shake, and slid to the ground. He had a skin tear on his left outer hand and 3 abrasions to his left outer knee. The areas were cleaned and Band-Aids applied. There was no documentation the resident's physician was notified. During an interview on 10/10/24 at 2:10 p.m., the Director of Nursing (DON) indicated the resident's physician was not notified of the incident and the nurse who documented the incident was terminated due to failure to notify the physician for previous incidents. The current 6/2022 "Fall Management Program" policy, provided by the DON, indicated the resident's physician should be notified immediately if injury was noted and provide information about the assessment findings.		occur as stated above by DON. All nurses and QMA's to be reeducated for fall policy which includes notifying physician immediately. 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 updated and is implementing a checklist form that nursing staff will use for every fall. It ensures that a physician is notified. When the form is completed, it is given to DON for her to follow up and ensure proper documentation is taking place consistently. 4. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place? DON or designee will review/discuss falls at M-F morning meeting	

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			DON or will audit all falls weekly for 8 weeks. If 100% compliance, audits will continue monthly. ED or designee will audit 2 random falls monthly	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift. This had the potential to affect the 80 residents who resided in the facility. Finding includes: There was no binder or record of the facility's fire drills to be reviewed. During an interview on 10/10/24 at 9:15 a.m., the Executive Director indicated she and the Maintenance Supervisor were unable to locate the fire drill book/log to verify drills had been completed 1 per quarter on every shift for the last year.	R 0092	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. has been established for all fire drill documentation and fire drills are being conducted so each shift completes a fire drill quarterly. 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. Corrective action includes binder being established for the new Maintenace director to complete and maintain records of fire drills.	11/01/2024

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			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; Director was educated on fire drill procedures on 10/10/24. Director will upload completed fire drills with signatures into 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 , fire drill reports will be reviewed for compliance on an ongoing basis indefinitely.	
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency Based on observation and interview, the facility failed to maintain an environment that was clean and in good repair related to stained, torn and frayed carpet for 3 of 3 units throughout the facility. (The 1st and 2nd Assisted Living (AL) floors and Memory Care Unit)	R 0144	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Carpet areas with frayed and torn areas were repaired by team and the housekeeping director cleaned	11/01/2024

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	Findings include: During the Environmental Tour on 10/10/24 at 12:19 p.m. with the Executive Director (ED), the following was observed: 1. 1st AL Floor a. The carpet was stained, torn, and frayed throughout the hallways and common areas, including the dining room. 2. 2nd AL Floor a. The carpet was stained, torn, and frayed throughout the hallways and common areas. 3. Memory Care Unit a. The carpet was stained, torn, and frayed throughout the hallways. During an interview on 10/10/24 at 12:19 p.m., the ED indicated she understood the carpet concern and had no additional information to provide.		carpet in all areas of concern. Director out to flooring company to provide a quote replacement of carpet for effected areas that have the potential to reoccur. 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. Corrective action stated above. 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 Maintenance Director and Housekeeping Director were reeducated sanitation and safety standards. The Housekeeping Director updated the carpet cleaning binder with affected areas as a focus to ensure more frequent cleaning takes place. Areas with and torn that could have the potential to reoccur will be for replacement.	

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			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; Environmental rounds will be done daily for 30 days, if 100% compliance, rounds will be reduced to weekly for 4 weeks and then monthly. Director of designee will do rounds weekly for 4 weeks then monthly.	
R 0243 Bldg. 00	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency Based on record review and interview, the facility failed to follow physician's orders for the treatment of skin tears and abrasions for 2 of 7 residents reviewed. (Residents 3 and 8) Findings includes: 1. The record for Resident 3 was reviewed on 10/9/24 at 1:37 p.m. Diagnoses included, but were not limited to Parkinson's disease, acute kidney failure, and high blood pressure. A Service Plan, dated 10/7/24, indicated the resident was cognitively intact for daily decision making and had a history of falls.	R 0243	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The DON will audit charts of all residents with skin tears to ensure all skin tears are also documented and monitored in the TAR. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what	11/01/2024

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	Nurses' Notes indicated the resident had numerous falls with injuries of skin tears and/or abrasions on the following days: - 2/5/24: skin tear to the lower back - 2/22/24: skin tear to the forehead. - 4/19/24: skin tear to the top of the left hand. - 5/2/24: skin tear to the left outer hand and 3 abrasions to the left outer knee. - 5/22/24: skin tear to the left forearm Physician's Orders, dated 6/21/21 and listed on the current 9/25/24 Physician Order Summary, indicated may cleanse small skin tear with normal saline, apply steri strips prn (as needed) until healed. May cleanse abrasion with normal saline, apply Bacitracin and dry dressing prn until healed. The Treatment Administration Records for the months of 2/2024-5/2024 indicated the treatments for the skin tears and/or abrasions were not signed out as being completed. During an interview on 10/10/24 at 11:30 a.m., the Director of Nursing indicated the treatments for the skin tears and/or abrasions had not been completed. 2. The record for Resident 8 was reviewed on 10/9/24 at 11:30 a.m. Diagnoses included, but were not limited to, angina, heart disease, and spinal stenosis. The 10/7/24 Service Plan indicated the resident was cognitively intact for daily decision making and had a history of falls. Nurses' Notes indicated the resident had several falls with injuries of skin tears on the following days:		corrective action will be taken? All residents with skin tears have the potential to be affected. DON will complete audit of chart and TAR to ensure skin tears and monitored, healing and documented properly. 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 DON will reeducate nursing staff adding standing order to TAR for daily check off for compliance. The DON will reeducate nurses and QMA's on notifying DON of any new skin issues on residents so DON will be able to be able to follow up The facility will alert the DON of any new skin issues on residents and will add standing orders for wound care for a skin tear to the TAR for daily treatment. The DON will audit charts weekly for wound care notes x8 weeks. If 100% compliance DON will audit	

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	- 5/5/24: skin tear to the left elbow. - 6/12/24: skin tear to the left arm. Physician's Orders, dated 6/21/21 and listed on the current 9/25/24 Physician Order Summary, indicated may cleanse small skin tear with normal saline, apply steri strips prn (as needed) until healed. May cleanse abrasion with normal saline, apply Bacitracin and dry dressing prn until healed. The Treatment Administration Records for the months of 5/2024 and 6/2024 indicated the treatments for the skin tears were not signed out as being completed. During an interview on 10/10/24 at 11:30 a.m., the Director of Nursing indicated the treatments for the skin tears had not been completed.		bi-weekly 4. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place? The DON or designee will audit MAR weekly to ensure with skin tears have orders in the TAR. This will be audited weekly for 8 weeks. If 100% compliance DON will audit bi-weekly. ED or designee will audit 2 random MAR and TAR monthly for residents with skin tears to ensure compliance.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation and interview, the facility failed to keep the kitchen clean and in good repair related to a build up of grime and grease on the food prep equipment, an uncovered trash can, dust on lighting fixtures, and undated food in the freezer for 1 of 1 kitchen observed. (The Main Kitchen)	R 0273	1. What corrective actions will be accomplished for those residents found to have been affected by deficient practice? The corrective action included deep cleaning of convection ovens, stove grates, and gridle to ensure there was no more grease and	11/01/2024

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	Findings include: During the Full Kitchen Sanitation tour with the Culinary Director on 10/9/24 at 8:44 a.m., the following was observed: a. There was grease and grime build up inside of both convection ovens. b. There was grease and grime build up on the stove grates. c. There was a build up of old dried food in the corners of the griddle. d. There was an uncovered trash can next to the stove that was full of garbage. e. There was dust on the light fixture in the kitchen prep area. f. There was an undated and open bag of chicken fritters inside the freezer. During an interview on 10/9/24 at 9:06 a.m., the Culinary Director indicated he just started 2 days ago and understood the concerns. During an interview on 10/10/24 at 12:27 p.m., the Executive Director indicated she understood the concerns and had no additional information to provide.		grime or dried food built up. New trash cans with lids were purchased to ensure trash cans not in use always have a lid on them. Light fixtures were cleaned to ensure no more dust, and all food was stored properly inside of the freezer. 2 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 staff are to be reeducated on sanitation policy and procedures and proper food storage. 3. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not re occur? Director will review/revise cleaning schedules to include all areas of concern. Cleaning lists to be maintained with a daily checklist. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur,	

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			i.e., what quality assurance program will be put in place Director or will perform rounds in the Food Service department to ensure cleaning lists, food storage, and all environmental standards are met daily x 30 days. If 100% compliance, rounds will be reduced to weekly for 4 weeks and then monthly. Executive Director or designee will do rounds weekly for 4 weeks then monthly Audit tools will be reviewed for compliance at monthly QA .	
R 0301 Bldg. 00	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency Based on observation and interview, the facility failed to ensure insulin pens and multi-dose insulin vials were dated upon opening and expired pens were not in use for 1 of 2 medication carts observed. (The AL first floor medication cart) Findings include: During an observation on 10/9/24 at 4:15 p.m., of the AL first floor medication cart with LPN 1, the following was observed: a. There was 1 multi-dose insulin vial of Lispro with no date when opened.	R 0301	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All insulin/medication not in compliance with labeling procedures were corrected immediately and anything expired was removed/destroyed. 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 using insulin have the potential to be affected. An audit	11/01/2024

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	b. There was 1 insulin pen of Glargine with no date when opened. c. There was 1 insulin pen of Humalog with no date when opened. d. There was 1 insulin pen of Humalog with an open date of 7/21/24. The manufacturer's instructions indicated the pen should be discarded 28 days after opening even if there was insulin remaining. During an interview on 10/9/24 at 4:30 p.m., the Director of Nursing indicated she was aware the insulin pens needed to be dated when they were opened.		of all insulin was conducted by DON to ensure mediation/pen/vials are all labeled with open dates and all medication was discarded as stated per manufacturer. 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; All nurses and QMA's qualified are to be reeducated on prescription drugs and the proper labeling procedures along with properly disposing insulin according to manufacturers instructions of discarding insulin. DON to review findings with pharmacy consultant to ensure monitoring of remains. 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 to audit carts weekly for 8 weeks, if 100% compliance audits will reduce to bi-weekly ED or will review pharmacy consultant notes monthly and review at QA monthly for an ongoing basis.	
R 0302 Bldg. 00	410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency Based on observation and interview, the facility failed to properly label over-the-counter medications with the resident's full name and physician's name for 1 of 2 medications carts observed and 4 of 4 residents. (AL first floor	R 0302	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All medication not in compliance	11/01/2024

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	medication cart and Residents 9, 10, 11, and 12) Findings include: 1. During an observation on 10/9/24 at 4:15 p.m. of the AL first floor medication cart with LPN 1, the following was observed: a. Resident 9: There was 1 bottle of Caltrate Bone Health, Cranberry tablets, Bayer Aspirin, Allergy Relief tablets, Vitamin D tablets, Turmeric tablets, and Pearls probiotic tablets with the resident's name and room number on the bottles. The physician's name was not on any of the bottles. b. Resident 10: There was 1 bottle of Vitamin D tablets and Calcium Citrate tablets with the resident's name and room number on the bottles. The physician's name was not on any of the bottles. c. Resident 11: There was 1 bottle of Calcium Citrate tablets, Melatonin tablets, and Vitamin D3 tablets with the resident's name and room number on the bottles. The physician's name was not on any of the bottles. d. Resident 12: There was 1 bottle of stool softener and Vitamin D3 with the resident's initials and room number on them. The physician's name and the resident's full name were not on the bottles. 2. There was 1 bottle of stool softener with no resident's name, room number or physician's name. During an interview on 10/9/24 at 4:30 p.m., the Director of Nursing indicated she was aware the over-the-counter medications were not labeled		with labeling procedures were corrected immediately. 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 who we administer medication to have the potential to be affected. An audit of each cart was conducted by DON to ensure all medications are labeled correctly. 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; All nurses and QMA's are to be reeducated on over the counter medication and the proper labeling procedures. DON created medication labels/stickers for nursing staff to use to ensure deficient practice does not reoccur. 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 to audit carts weekly for 8 weeks, if 100% compliance audits will reduce to bi-weeklyED or will review pharmacy consultant notes monthly and review at QA monthly for an ongoing basis.	

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	correctly.			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance Based on record review and interview, the facility failed to ensure clinical records were accurately documented related to a readmission assessment and sutures for 1 of 7 residents reviewed. (Resident 3) Finding includes: The record for Resident 3 was reviewed on 10/9/24 at 1:37 p.m. Diagnoses included, but were not limited to Parkinson's disease, acute kidney failure, and high blood pressure. A Service Plan, dated 10/7/24, indicated the resident was cognitively intact for daily decision making and had a history of falls. A Nurses' Note, dated 9/29/24 at 8:25 p.m., indicated the resident returned from the hospital and had bruising to the right forehead with a "dime size lump" and purple bruising to the right orbital (eye) area. There was no documentation the resident had sutures to his forehead. Nurses' Notes, dated 10/1/24 at 9:30 a.m., indicated "spoke with the Nurse Practitioner [NP] who gave a new order to have skilled nursing remove the sutures to the forehead on 10/4/24." During an interview on 10/10/24 at 1:30 p.m., the Director of Nursing indicated there should have been an assessment of the sutures at the time the resident returned from the hospital.	R 0349	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? DON will audit all new admission or readmission charts within the last 30 days. DON or designee to ensure there were no document skin issues, and resident do not currently have skin issues. 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 when returning from the hospital, being readmitted or newly admitted into the facility have the potential to be affected by this deficient practice. The DON will reeducate all nurses to complete a thorough skin examination on the resident and note any abnormalities. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not	11/01/2024

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		A. BUILDING 00 B. WING	10/10/2024

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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			recur? DON to reeducate nurses on skin assessment and how to properly fill it out. If issue is present, the DON or will be notified immediately. MD will be notified for treatment orders. The DON or will follow up weekly for notes and status or skin issues. 4. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place? The DON or will be notified of skin issues presented at that time. The DON or will follow up by checking to make sure nursing notes are accurately charted and policy was followed regarding the skin issue. DON or designee will check new admission or readmissions weekly x8 weeks. If 100% compliance, DON or will check monthly. ED or will audit 2 random new and/or readmissions monthly.	

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