

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/16/2025	
NAME OF PROVIDER OR SUPPLIER RITTENHOUSE VILLAGE AT NORTHSIDE		STREET ADDRESS, CITY, STATE, ZIP CODE 1251 W 96TH ST, INDIANAPOLIS, , 46260					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...			(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: April 15 and 16, 2025 Facility number: 003282 Residential Census: 72 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on April 21, 2025.	R 0000	The following Plan of Correction for Rittenhouse Village at Northside regarding the statement of Deficiencies dated April 16th 2025. This Plan of Correction is not to be constructed as an admission of our agreement with the findings and conclusions in the statement of Deficiencies, or any related sanction or fines. Rather, it is a submitted as confirmation of our ongoing efforts to comply with the statutory and regulatory requirement's. 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 the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.				
R 0123	Personnel - Nonconformance 410 IAC 16.2-5-1.4(h)(1-10) (h) The facility shall maintain current and accurate personnel	R 0123	R0123 What corrective action(s) will be			05/02/2025	

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records for all employees. The personnel records for all employees shall include the following:

- (1) The name and address of the employee.
- (2) Social Security number.
- (3) Date of beginning employment.
- (4) Past employment, experience, and education, if applicable.
- (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable.
- (6) Position in the facility and job description.
- (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills.
- (8) Signed acknowledgement of orientation to residents' rights.
- (9) Performance evaluations in accordance with facility policy.
- (10) Date and reason for separation.

accomplished for those residents found to have been affected by the deficient practice: Executive Director and Business Office Manager ensure appropriate organization and documentation of both new hires and current associate have job description and job specific checklist for all employees by competing a.

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 facility has determined that 100% of residents have the potential to be affected by the deficiency.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Executive Directive will regularly audit compliance with standard and compel compliance if any deficiencies are found. Business Office Manager will additionally monitor compliance during the new hire onboarding process, document any deficiencies to the Executive Director. The Executive Director will in-service department to ensure every new hire complete department specific orientation through documentation from department managers regarding

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	Based on interview and record review, the facility failed to ensure general, and job specific orientations were documented, and job descriptions were in the employee files for 5 of 5 new employees reviewed for personnel records. (QMA 4, CNA 6, LPN 7, QMA 5, and CNA 8) Findings include: The employee records were reviewed on 4/16/25 at 10:17 a.m. 1. QMA 4 was hired on 10/26/24. The facility was unable to provide documentation to show job specific orientation was completed by the employee after hire and the employee file did not include a job description. 2. CNA 6 was hired on 7/30/24. The facility was unable to provide documentation to show job specific orientation was completed by the employee after hire and the employee file did not include a job description. 3. LPN 7 was hired on 12/18/24. The facility was unable to provide documentation to show job specific orientation was completed by the employee after hire and the employee file did not include a job description. 4. QMA 5 was hired on 8/23/24. The facility was unable to		compliance with the standard. Department manager will be required by Executive Director to utilize these tools and document their utilization. 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 first and initial 100% audit will completed by May 2nd 2025, and quarterly until the next annual ISHD survey in 2026. The Executive Director will commence auditing all new hire documentation through the new hire checklist sheet, completed by Business Office Manager for each new hire and signed and dated by Business Office Manager & Executive Director. By what date the systemic changes will be completed: May 2nd 2025	
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provide documentation to show job specific orientation was completed by the employee after hire and the employee file did not include a job description.

5. CNA 8 was hired on 8/26/24. The facility was unable to provide documentation to show general orientation or job specific orientation was completed by the employee after hire.

During an interview, on 4/16/25 at 10:53 a.m., the Executive Director (ED) indicated the facility could not provide documentation of general orientation and job specific orientation for the employees and indicated the facility should have kept records of these documents in all employee files.

During an interview, on 4/16/25 at 12:04 p.m., the ED indicated the facility followed all state regulations.

A facility document, titled "EMPLOYEE FILE DOCUMENTATION (INDIANA)," undated and received from the ED on 4/16/25 at 12:13 p.m., indicated "...Personnel records include...Job title...Job description...Documentation or orientation/initial and annual training...."

Based on interview and record review, the facility failed to

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ensure general, and job specific orientations were documented, and job descriptions were in the employee files for 5 of 5 new employees reviewed for personnel records. (QMA 4, CNA 6, LPN 7, QMA 5, and CNA 8)

Findings include:

The employee records were reviewed on 4/16/25 at 10:17 a.m.

1. QMA 4 was hired on 10/26/24. The facility was unable to provide documentation to show job specific orientation was completed by the employee after hire and the employee file did not include a job description.

2. CNA 6 was hired on 7/30/24. The facility was unable to provide documentation to show job specific orientation was completed by the employee after hire and the employee file did not include a job description.

3. LPN 7 was hired on 12/18/24. The facility was unable to provide documentation to show job specific orientation was completed by the employee after hire and the employee file did not include a job description.

4. QMA 5 was hired on 8/23/24. The facility was unable to provide documentation to show job specific orientation was

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	completed by the employee after hire and the employee file did not include a job description. 5. CNA 8 was hired on 8/26/24. The facility was unable to provide documentation to show general orientation or job specific orientation was completed by the employee after hire. During an interview, on 4/16/25 at 10:53 a.m., the Executive Director (ED) indicated the facility could not provide documentation of general orientation and job specific orientation for the employees and indicated the facility should have kept records of these documents in all employee files. During an interview, on 4/16/25 at 12:04 p.m., the ED indicated the facility followed all state regulations. A facility document, titled "EMPLOYEE FILE DOCUMENTATION (INDIANA)," undated and received from the ED on 4/16/25 at 12:13 p.m., indicated "...Personnel records include...Job title...Job description...Documentation or orientation/initial and annual training...."			
R 0244	Health Services - Noncompliance	R 0244	R0244	05/02/2025

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410 IAC 16.2-5-4(e)(4) (4) Preparation of doses for more than one (1) scheduled administration is not permitted. Based on observation, interview and record review, the facility failed to ensure staff did not prepare medication for more than one medication administration for 1 of 1 staff member reviewed for medication administration. (QMA 5) Findings include: During an observation of the medication administration, on 4/15/25 at 12:12 p.m., QMA 5 was observed to have five (5) medication cups of medications already prepared in the top drawer of the medication cart. The cups had resident names or initials written on the cups. During an interview, on 4/15/25 at 12:16 p.m., QMA 5 indicated only one medication was to be prepared at a time. During an interview, on 4/16/25 at 12:04 p.m., the Executive Director indicated the facility did not have a policy addressing presetting medications, and there should be no presetting of medications. She indicated the facility followed the state regulations. Based on observation, interview	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: QMA 5 was given a written warning and in-serviced on not pre-setting per state regulations.	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 facility has determined that 100% of residents have the potential to be affected by the deficiency.	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 of Health & Wellness and or designee will audit for pre-set medications. Randomly auditing medication cart three (3) times a week for one (1) month then one (1) time weekly for three (3) months.	How the corrective action(s) will be
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R 0246	Health Services - Deficiency 410 IAC 16.2-5-4(e)(6) (6) PRN medications may be administered by a qualified medication aide (QMA) only upon	R 0246	R0246 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Director of	05/02/2025

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authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a 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 interview and record review, the facility failed to ensure the Qualified Medication Aide notified a licensed nurse and received prior approval to administer as needed (PRN) narcotics for 1 of 8 residents reviewed for prior authorization. (Resident 4)

Findings include:

The clinical record for Resident 4 was reviewed on 4/15/25 at 11:32 a.m. The diagnoses included, but were not limited to, hypertension, chronic obstructive pulmonary disease (COPD), and chronic pain.

A physician's order, dated 1/27/25, indicated to give hydrocodone-acetaminophen (a narcotic pain reliever) 10 milligrams/325 milligrams three times a day as needed for chronic pain.

The Medication Administration Record (MAR) indicated the following:

Health & Wellness and or designee will provide an in-service to all QMAs and Nurses on prior approval from Nurse before administering as needed (PRN) narcotics.

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 facility has determined that 100% of residents have the potential to be affected by the deficiency.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: In-service held May 1st 2025 by Director of Health & Wellness for all QMAs and Nurses. Any clinical staff member out of compliance with facility's policies and protocols relating to prior approval to administer as needed (PRN) narcotics.

How the corrective action(s) will be monitored to ensure the deficient

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a. On 4/7/25, the PRN narcotic was administered by QMA 2. There was no documentation to show a licensed staff member was made aware of or approved of the administration of the narcotic.

b. On 4/9/25 and 4/13/25, the PRN narcotic was administered by QMA 1. There was no documentation to show a licensed staff member was made aware of or approved of the administration of the narcotic.

c. On 4/15/25 and 4/16/25, the PRN narcotic was administered by QMA 3. There was no documentation to show a licensed staff member was made aware of or approved of the administration of the narcotic.

During an interview, on 4/16/25 at 11:25 a.m., the Director of Health and Wellness indicated it was her responsibility to document the permission given for the PRN administration.

During an interview, on 4/16/25 at 11:32 a.m., QMA 4 indicated when a resident requested a PRN pain medication, the nurse should be notified to get approval prior to administering the PRN medication. The approval would be documented in the residents' chart. The nurse would also document the

practice will not recur, i.e. What quality assurance program will be put into place: The Director of Health & Wellness and or designee will audit documentation three (3) times a week for one (1) month and as needed, then one (1) time a week for three (3) months and as needed to ensure QMA's are receiving prior approval from Nurse to administer as needed (PRN) narcotics.

By what date the systemic changes will be completed: May 2nd 2025

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approval in the resident's chart.

During an interview, on 4/16/25 at 11:38, QMA 5 indicated she needed to get permission from a nurse to give PRN medication. She was not able to indicate where the authorization from the nurse would be documented.

A current facility policy, titled "Documenting Medication Pass," dated 6/10/24 and received from the Director of Health Services on 4/16/25 at 8:54 a.m., indicated "...PRN medication may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician...Document in the resident record that the facility's licensed nurse was contacted...and permission was granted to administer the medication, including time of contact...Obtain permission to administer the medication...Ensure the resident's record is cosigned by the licensed nurse who gave permission...."

Based on interview and record review, the facility failed to ensure the Qualified Medication Aide notified a licensed nurse and received prior approval to administer as needed (PRN) narcotics for 1 of 8 residents reviewed for prior authorization. (Resident 4)

Findings include:

The clinical record for Resident 4 was reviewed on 4/15/25 at 11:32 a.m. The diagnoses included, but were not limited to, hypertension, chronic obstructive pulmonary disease (COPD), and chronic pain.

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c. On 4/15/25 and 4/16/25, the PRN narcotic was administered by QMA 3. There was no documentation to show a licensed staff member was

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licensed nurse was contacted...and permission was granted to administer the medication, including time of contact...Obtain permission to administer the medication...Ensure the resident's record is cosigned by the licensed nurse who gave permission...."			
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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