| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | A. BUILDING<br>B. WING | 11/17/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| RITTENHOUSE VILLAGE AT NORTHSIDE | 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 |
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| R 0000 | INITIAL COMMENTS<br><br>This visit was for the Investigation of Complaints IN00366647 and IN00363850.<br><br>Complaint IN00366647-Substantiated. State deficiencies related to the allegations are cited at R0052.<br><br>Complaint IN00363850-Substantiated. No deficiencies related to the allegations are cited.<br><br>Survey dates: November 16 and 17, 2021<br><br>Facility number: 003282<br><br>Residential Census: 75<br><br>This State Residential Finding is cited in accordance with 410 IAC 16.2-5.<br><br>Quality review was completed on November 22, 2021. | R 0000 | The Following is the Plan of Correction for the Rittenhouse Village at Northside in regards to the Statement of Deficiencies dated November 17, 2021. 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.<br>We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors.<br>We remain committed to delivery of quality health care services and will continue to make changes and improvement to satisfy that objective. | |
| R 0052 | Residents' Rights - Offense<br><br>410 IAC 16.2-5-1.2(v)(1-6)<br><br>(v) Residents have the right to be free from:<br><br>(1) sexual abuse;<br><br>(2) physical abuse; | R 0052 | R052<br><br>.<br>What corrective action(s) will be accomplished for those residents found to have been affected by the | 12/17/2021 |

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| | (3) mental abuse;<br><br>(4) corporal punishment;<br><br>(5) neglect; and<br><br>(6) involuntary seclusion.<br><br>Based on observation, interview and record review, the facility failed to ensure a resident who was at risk for elopement was free from neglect, when staff failed to account for all Memory Care residents after a fire alarm sounded and a resident left the facility, without staff knowledge, for an unknown amount of time for 1 of 1 resident reviewed for elopement. (Resident B)<br><br>Finding includes:<br><br>A document, titled "Indiana State Department of Health Survey Report System," dated November 05, 2021, indicated "...Resident was found in the parking lot by staff member...."<br><br>A facility document, titled "INVESTIGATION OF INCIDENT REPORT," provided by the Executive Director on November 16, 2021, indicated Home Health Aide (HHA) 1 was exiting the building, heading toward her car, when she heard the alarms going off. She went back in to check and was told by LPN 2 to get all the residents, of the Memory Care Unit, together and to count them. She assisted with the residents and then left. | | deficient practice? Resident B suffered no negative side effects due to these findings.<br><br>.<br>How the facility will identify other residents<br>having the potential to be affected by the same deficient practice and what<br>corrective actions will be taken? All<br>memory care residents have the potential to be affected.<br><br>.<br>What measures will be put into place or what<br>systemic changes the facility will make to ensure that the deficient practice<br>does not recur: All staff re-educated on Abuse policy, missing resident policy<br>and fire drill policy on November 11th, 2021. Head count form created on<br>November 5th, 2021. | |

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| | She returned an hour later and found the resident in the employee parking lot. A statement, on the same form, provided by HHA 3 indicated the fire alarms were going off at 8:05 a.m. At 8:15 a.m., HHA 3 walked outside halfway around the building to the employee lot and did not see anyone. At 8:25 a.m., he sat in a chair by the fire exit door in the hallway until breakfast arrived at 8:32 a.m. Per the investigation form the possible cause for the incident was "Fire alarm" and "...ACTIONS TAKEN TO PREVENT FURTHER INCIDENTS...Head Count...."<br><br>The record for Resident B was reviewed on November 16, 2021. Diagnoses included, but were not limited to, dementia with behavioral disturbance, edema and major depressive disorder.<br><br>A nursing note, dated November 05, 2021, indicated Resident B was found in the back parking lot by a staff member. The entry did not have a time to indicated when the resident was found or returned to the facility.<br><br>During an observation, on November 16, 2021 at 11:01 a.m., the back parking lot was observed to be enclosed and had a wooden privacy fence. The fence ended at the access road to the left of the main | | .<br>How the corrective action(s) will be monitored<br>to ensure the deficient practice will not recur. Head Count form will be<br>completed after every fire alarm, and will be monitor monthly during QA<br>meeting.<br><br>.<br>By what date the systemic changes will be<br>completed? December 17th, 2021. | |

entrance and a border of bushes separated 96th Street from the front entrance.

During an interview, on November 16, 2021 at 12:15 p.m., HHA 1 indicated she had an appointment on November 05, 2021. She heard the alarm and went back in the building to assist with the residents and do a head count, after assisting the Memory Care Staff she left and went to her appointment. She returned about 9:15 a.m.- 9:30 a.m., and found Resident B, with her walker, in the back parking area wearing her coat and hat. The resident was unattended. She returned the resident to the facility.

During an interview, on November 16, 2021 at 12:20 p.m., Cook 4 indicated in the case of a fire alarm/drill she would assist to get the residents to safety and then assist with a head count.

During an interview, on November 16, 2021 at 12:25 p.m., Staff 5 indicated in the case of a fire alarm/drill she would check the fire panel to see where the fire was, get the residents in her area to safety and then account for all residents and visitors.

During an interview, on November 16, 2021 at 1:20 p.m., the Executive Director

indicated Resident B had never been exit seeking in the past. She indicated the amount of time the resident was out of the facility, unattended, was unknown. She went out between 8-8:30 a.m., November 5th, 2021, and LPN 2 went out and then brought the resident to her office at 10:00 a.m.

During an interview, on November 16, 2021 at 1:20 p.m., the Facility Operations Manager indicated the alarm event was at about 8:10 a.m. and was related to burnt toast in the kitchen. The sprinkler system went off and they had five leaks in the system, causing them to shut the water off. Within the first alarm event, the alarm sounded again, it was activated twice between 8:10 a.m. and 8:40 a.m.

During the same interview, on November 16, 2021 at 1:20 p.m., the Executive Director indicated Resident B had never been exit seeking before and her educated guess was Resident B went out the door when the alarm was sounding, as all doors unlock when the alarm sounds.

During a telephone interview, on November 16, at 1:41 p.m., LPN 2 indicated the alarm sounded about 8:10 a.m. He went to check the fire box and then went to the kitchen. He did not

find anything in the kitchen so he returned to the fire box and it said kitchenette. He went to the kitchenette and was informed toast had been burnt. He tried to reset the panel and went out to turn off the main. The Memory Care Staff was to ensure a head count was completed and to monitor the doors. A staff member returning from break found Resident B in the parking lot. Once the resident was found another head count was completed.

During an interview, on November 16, 2021 at 1:52 p.m., with both the Executive Director and Memory Care Director, the Memory Care Director indicated they were unable to provide a head count sheet for November 05, 2021, for the Memory Care residents.

During an interview, on November 16, 2021 at 1:53 p.m., HHA 3 indicated, on November 05, 2021, the alarm came on and he got everyone (residents) where he could see them between the exit door and the door to memory care, located by the kitchen area. He went to check the doors and realized they were not secured so he went outside and looked around, walked the parking lot by the back exit and returned to the unit. He did not see anyone. Upon return to the unit, he started to do a head count, he

counted between 18-19 residents. He indicated he did not know how many residents were on the unit, he counted heads. He did not have a list of names to check off or go by and had to rely on staff which was working with him on the unit. He indicated the alarm sounded for about 8-10 minutes.

During an interview, on November 17, 2021 at 10:00 a.m., the Executive Director indicated on November 05, 2021 there were 24 residents residing on the Memory Care Unit.

During an interview, on November 17, 2021 at 10:45 a.m., the Director of Nursing indicated a head count of all residents was part of the fire drill policy.

During an interview, on November 17, 2021 at 11:20 a.m., the Director of Nursing indicated the staff did not follow the facility policy related to getting a head count of all residents, when the fire alarm sounded.

A current facility policy, titled "FIRE POLICY," provided by the Director of Facility Operations on November 17, 2021 at 10:49 a.m., indicated "...PERSONNEL IN THE AREA OF THE FIRE...Account for all residents...PERSONNEL IN

THE NON-FIRE AREA...Account for all residents...ACTIVITY PERSONNEL, WHEN ALARM SOUNDS YOU SHOULD...Help with accounting for residents-checking off names as evacuated...."

This State finding relates to Complaint IN00366647.

Based on observation, interview and record review, the facility failed to ensure a resident who was at risk for elopement was free from neglect, when staff failed to account for all Memory Care residents after a fire alarm sounded and a resident left the facility, without staff knowledge, for an unknown amount of time for 1 of 1 resident reviewed for elopement. (Resident B)

Finding includes:

A document, titled "Indiana State Department of Health Survey Report System," dated November 05, 2021, indicated "...Resident was found in the parking lot by staff member...."

A facility document, titled "INVESTIGATION OF INCIDENT REPORT," provided by the Executive Director on November 16, 2021, indicated Home Health Aide (HHA) 1 was exiting the building, heading toward her car, when she heard the alarms going off. She went back in to check and was told by

LPN 2 to get all the residents, of the Memory Care Unit, together and to count them. She assisted with the residents and then left. She returned an hour later and found the resident in the employee parking lot. A statement, on the same form, provided by HHA 3 indicated the fire alarms were going off at 8:05 a.m. At 8:15 a.m., HHA 3 walked outside halfway around the building to the employee lot and did not see anyone. At 8:25 a.m., he sat in a chair by the fire exit door in the hallway until breakfast arrived at 8:32 a.m. Per the investigation form the possible cause for the incident was "Fire alarm" and "...ACTIONS TAKEN TO PREVENT FURTHER INCIDENTS...Head Count...."

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| | observed to be enclosed and had a wooden privacy fence. The fence ended at the access road to the left of the main entrance and a border of bushes separated 96th Street from the front entrance.<br><br>During an interview, on November 16, 2021 at 12:15 p.m., HHA 1 indicated she had an appointment on November 05, 2021. She heard the alarm and went back in the building to assist with the residents and do a head count, after assisting the Memory Care Staff she left and went to her appointment. She returned about 9:15 a.m.- 9:30 a.m., and found Resident B, with her walker, in the back parking area wearing her coat and hat. The resident was unattended. She returned the resident to the facility.<br><br>During an interview, on November 16, 2021 at 12:20 p.m., Cook 4 indicated in the case of a fire alarm/drill she would assist to get the residents to safety and then assist with a head count. | | | |

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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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