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	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RITTENHOUSE VILLAGE AT NORTHSIDE	1251 W 96TH ST INDIANAPOLIS, IN 46260

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R 0000 Bldg. 00	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 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance 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)	R 0123	R0123 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Executive	05/02/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pamala Williams	Executive Director	05/02/2025

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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	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 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.		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 mangers regarding	

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	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...."		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	
R 0244 Bldg. 00	410 IAC 16.2-5-4(e)(4) Health Services - Noncompliance			

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	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.	R 0244	R0244 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	05/02/2025

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			monitored to ensure the deficient practice will not recur, i.e. What quality assurance program will be put into place: To assist with ongoing compliance the Director of Health & Wellness and or designee will complete random audits for three (3) months and pre-set medications will be reported to Executive Director and or designee. By what date the systemic changes will be completed: May 2nd 2025	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency 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	R 0246	R0246 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Director of 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.	05/02/2025

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	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: 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 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		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 polices and protocols relating to prior approval to administer as needed (PRN) narcotics. 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 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)	

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	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...."		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	