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	06/03/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00460660. Complaint IN00460660-State deficiencies related to the allegations are cited at R0052. Survey date: June 3, 2025. Facility number: 003282 Residential Census: 67 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on June 12, 2025.	R 0000	The following Plan of Correction for Rittenhouse Village at Northside regarding the statement of Deficiencies dated June 3rd 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 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense Based on interview and record review, the facility failed to ensure a resident was free from neglect, when a resident with a diagnosis of dementia, who was displaying a recent change of condition, wandered away from the facility to an unknown location and was gone for approximately 14 hours	R 0052	R0052 What corrective action(s) will be accomplished for those residents found to have been affected by the	06/12/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pamala Williams	Executive Director	06/27/2025

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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	for 1 of 1 resident reviewed for elopement. (Resident B) This deficient practice resulted in Resident B being located approximately 14 hours later, on Interstate 465 (a busy 8 lane interstate road). Findings include: A facility reported incident (FRI), dated 6/1/25, indicated on 5/31/25 at 6:01 p.m., Resident B went outside the facility to walk around the community and did not return. The clinical record for Resident B was reviewed on 6/3/25 at 9:40 a.m. The diagnoses included, but were not limited to, Alzheimer's dementia, type 2 diabetes, and hypertension. The resident was admitted to the facility in 2023. An elopement risk assessment prior to 6/2/25 was not found in Resident B's clinical record. A nursing progress note, dated 5/2/25 at 11:30 a.m., indicated Resident B had returned to the facility after being in another facility. He returned with his billfold, keys, FOB (transmitter for remote entry), and cell phone. A nursing progress note, dated 5/2/25 at 2:25 p.m., indicated a call was placed to Resident B's son and he gave permission to remove the car keys from the resident. A nursing progress note, dated 5/31/25 at 6:00 p.m., indicated Resident B was out in the parking lot area with another resident. Resident B had walked to the front of the building and to the parking lot again. Per the front desk, the resident did not return inside the community.		deficient practice; DHW completed Slums and elopement assessment 100% residents living on the assisted living, to monitor for more risk of elopement to be completed by June 9th 2025 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 all residents on the assisted living have the potential to be affected by the deficiency. All newly admitted residents will have an elopement risk assessment completed upon move in and all residents in the facility will be assessed semi-annually. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Slum and elopement assessment will be completed semi-annually to evaluate risk. If risk is assessed their physician will be notified along with family/POA and the resident will be secured and monitored. condition to evaluate risk.	

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	A nursing progress note, dated 5/31/25 at 7:00 p.m., indicated the receptionist reported the resident left the facility at 6:00 p.m. and had not returned. A nursing progress note, dated 5/31/25 at 8:35 p.m., indicated the inside and the perimeter of the community was searched. Resident B was unable to be located. A nursing progress note, dated 5/31/25 at 9:22 p.m., indicated the police arrived at the community for an intake of Resident B's information. A nursing progress note, dated 6/1/25 at 8:18 a.m., indicated the community was contacted by the hospital and informed Resident B had been taken to the emergency room. The physician completed an assessment and no injuries were found. A nursing progress note, dated 6/1/25 at 6:00 p.m., indicated Resident B returned to the facility from the hospital after he had eloped and was missing for 12-13 hours. The resident was found along Interstate 465. The resident had been given intravenous fluids for dehydration, a urinalysis was completed to check for a urinary tract infection, he was showered and put in clean clothing. His clothes were filthy. Resident B denied pain or injury. The resident was "chatty" and hallucinated at times. Resident B was placed in the memory care unit. During an interview, on 6/3/25 at 8:30 a.m., Director of Nursing 2 indicated the resident was currently in a psychiatric hospital due to the resident wandering away from the facility. Resident B had his keys taken from him on 5/2/25 after he returned from a hospital stay. The day his		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; In-service all staff on elopement was completed June 12th 2025, and slum and assessments completed June 9th 2025 and will complete semi-annually and or change of condition. If risk is identified their doctor and POA will be notified, resident will be placed in secured setting. Assessments will be completed with 100% of residents. An audit will be performed quarterly by the Executive Director to ensure 100% compliance. By what date the systemic changes will be completed June 12th 2025	

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	keys were removed from his possession, he had told staff he had just returned from London. After losing his driving privileges, the resident would walk the facility grounds, go out, and look at his car. The resident was last seen on 5/31/25 at approximately 6:00 p.m. The facility began the elopement procedure, searched inside and outside the facility, and searched the surrounding neighborhoods. The police were notified Resident B was missing around 8:48 p.m. The police responded to the facility at 9:22 p.m. The facility received a phone call from the hospital on 6/1/25 at about 8:18 a.m., notifying the facility Resident B was in the hospital. The resident was found on Interstate 465. During an interview, on 6/3/25 at 10:35 a.m., the Director of Nursing indicated the resident returned to the facility on 6/1/25 and was placed on the locked memory care unit. She indicated the resident was not able to recall his whereabouts for the time he had been missing. During an interview, on 6/3/25 at 11:13 a.m., Receptionist 1 indicated she had noticed a change in mental status after Resident B had returned from the hospital. His keys had been taken from him. During an interview, on 6/3/25 at 11:20 a.m., Receptionist 2 indicated Resident B had changes in his cognitive state. Resident B thought his cell phone, or his television remote would start his car. He did not make sense when he talked, was paranoid, and thought people were out to get him. During an interview, on 6/3/25 at 11:26 a.m., QMA 3 indicated she had noticed little changes in Resident B. He was quieter and less friendly.			

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	During an interview, on 6/3/25 at 11:32 a.m., the Director of Nursing indicated she was not informed of any changes in Resident B's behaviors. The facility felt Resident B was fine to go out to walk the grounds and parking lot. During an interview, on 6/3/25 at 11:32 a.m., the Executive Director indicated Resident B did go out a lot but had never left the facility grounds after his car keys were taken. During a telephone interview, on 6/3/25 at 12:31 p.m., Receptionist 6 indicated she was working the evening Resident B left the facility. She indicated two men entered the facility and were signing in when the resident walked out. He would frequently walk out and look at his car. She indicated he went to the right of the building first (east) then back left (west) towards another resident. A female resident came back into the building, and told Receptionist 6, Resident B said he had a gun in his room. When Receptionist 6 looked back, she saw Resident B standing there. She was unable to give a time frame but indicated when she looked back again Resident B was gone. After about 35 minutes, she called Receptionist 1 and informed her of the situation and who to alert. She attempted to contact QMA 7. When QMA 7 was notified, the resident had been gone for a while, QMA 7 told her it was okay because the resident was allowed to go out. She then informed QMA 7 about the gun comment. Her shift ended at 7:00 p.m., so she left. During an interview, on 6/3/25 at 12:42 p.m., the Executive Director indicated they told the responding police officer the resident had dementia. During a telephone interview, on 6/3/25 at 1:00			

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	p.m., Detective 8 indicated an Indiana State Trooper found the resident around Interstate 465. There was a four-hour delay in contacting the police to report him missing. The facility told the police Resident B walked in the parking lot and around the campus grounds. During an interview, on 6/3/25 at 1:19 p.m., the Director of Nursing indicated Receptionist 1 contacted the Executive Director and the nurse on duty contacted her. Both reported to the facility to search for the resident. A current facility policy titled, "Personal Rights," dated 06/10/24 and received from the Executive Director on 06/03/25 at 12:42 p.m., indicated, "...Community Management ensures that...Residents are not subjected to...Neglect...." A current facility policy titled, "Abuse, Neglect, and Exploitation" dated 06/10/24 and received from the Executive Director on 06/03/25 at 12:42 p.m., indicated, "...Resident...abuse...neglect...are prohibited...." This citation relates to Complaint IN00460660.			