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	11/29/2023

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 Complaints IN00421484, IN00419290 and IN00417835. Complaint IN00421484 - State deficiencies related to the allegations are cited at R0052. Complaint IN00419290 - No deficiencies related to the allegations are cited. Complaint IN00417835 - No deficiencies related to the allegations are cited. Survey dates: November 28 and 29, 2023. Facility number: 003282 Residential Census: 80 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on December 4, 2023.	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to ensure a resident was safe from physical abuse when the resident and a staff member got into a verbal altercation which led to a physical	R 0052	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?	01/31/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Daniel Fink	Executive Director	12/20/2023

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	altercation for 1 of 3 residents reviewed for abuse. (Resident B) Finding includes: A facility document, titled "INDIANA STATE DEPARTMENT OF HEALTH SURVEY REPORT SYSTEM," indicated, on 11/06/23, a male resident became angry with a male staff member because the resident thought the staff member passed him up for breakfast service two times. A shouting match ensued followed by a physical altercation between the resident and the staff member. During an observation and interview, on 11/28/23 at 9:34 a.m., Resident B was resting in bed. He was alert and able to make his needs known. He indicated he had an incident with a staff member. He got into a shouting match with Staff 2. He could not recall everything. The record for Resident B was reviewed on 11/28/23 at 1:13 p.m. Diagnoses included, but were not limited to, chronic myeloproliferative disease (the bone marrow makes too many red blood cells, white blood cells, or platelets) hypothyroidism, and schizoaffective disorder bipolar type. A nursing note, dated 11/06/23 at 8:30 a.m., indicated the nurse was notified of a verbal altercation turned physical between a staff member and the resident. Resident B vaguely remembered saying something to the staff member but apologized later. The resident was assessed for injury and a minor bruise was found on his right shoulder, but the nurse was unable to definitively say how the resident sustained the bruise. A timeline of the incident indicated, on 11/06/23,		*Because almost 100% of assisted living residents heard about this altercation, the Executive Director and Director of Health and Wellness will provide programs to the residents reviewing the concepts behind resident rights and abuse. The programs will include appropriate definitions of each, the organization's philosophies regarding resident rights and abuse, and strong encouragement to report suspicious behaviors just as soon as they happen to a staff member or management staff. The programs will also remind residents of outside resources available to assist them privately such as the Ombudsman and Adult Protective Services.* 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 assumption by the facility is that almost 100% of assisted living residents have heard something about this altercation. As a result, 100% of residents will be included in the above outlined programs unless they decide not to participate.* What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not	

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	the Executive Director contacted Staff 2 via telephone. Staff 2 indicated "...he had instigated the physical altercation, he didn't really know why he did it, that he kind of 'snapped'. He confessed that he clearly knew that he did the wrong thing and should have walked away from the situation and sought help...." A statement from Dietary Supervisor 4 indicated Staff 2 was passing meal trays to the residents and Resident B started to yell at him about not being served. Staff 2 explained to the resident he was coming to the table to serve him. Resident B indicated "you are leaving me out on purpose everybody at this table has their food but me". Resident B continued to yell at Staff 2 using profanity. Staff 2 indicated to Resident B "you need to leave the dining room." Resident B continued to use profanity and got up out of his chair. Dietary Supervisor 4 then observed both men on the ground with Staff 2 on top of Resident B. Resident B punched Staff 2 in the face several times and Staff 2 did hit back. During the altercation, Resident B was yelling out racial slurs. A statement from QMA 3 indicated the QMA did not witness the beginning of the altercation but did see them both on the floor punching each other. Staff did get them separated while they both were yelling at each other. A statement from QMA 5 indicated the QMA walked to the dining room and heard yelling/arguing. She entered the dining room to break up the fight. She did get them to spilt up. When she entered the dining room, Resident B was on the ground on his back and Staff 2 was over the top of him. Resident B was trying to punch Staff 2.		recur. *The Executive Director and Director of Health and Wellness will also provide a mandatory inservice for all team members with a comprehensive overview of resident rights and abuse. In addition to the mandatory inservices, all team members will be required to complete their annual Relias (contracted internet) training on resident rights and abuse in assisted living by January 31, 2024 whether due or not in their annual training plan. Additional specialized mandatory training will be provided focusing on handling of residents should their behavior become physically or verbally aggressive.* *New team members will be required to complete Relias (contracted internet) training on resident rights and abuse prior to all other new hire training included in their training plan.* How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. *Attendance records will be documented at both resident and team member meetings and checked by the Executive Director to ensure full compliance. Executive Director will document that 100% of team members have completed their Relias (contracted internet) training on resident rights*	

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	Staff 2 was terminated from employment on 11/10/22. During an interview, on 11/28/23 at 12:07 p.m., the Executive Director indicated no formal in-service on abuse was provided to the staff after the incident. He did speak to staff about abuse but did not have a formal sign-in in-service. During an interview, on 11/28/23 at 12:11 p.m., QMA 3 indicated on the morning of the incident, she heard "help, help" from the dining room. When she arrived in the dining room, Staff 2 and Resident B were on the floor fighting. Staff members did get the two separated. She could not recall if she observed either of the two hit the other. Each one had blamed the other for starting the altercation. She did not know how it started. During an interview, on 11/28/23 at 12:16 p.m., Dietary Supervisor 4 indicated she had heard words exchanged. Resident B felt he had been left out on breakfast service and was yelling at Staff 2 because he was passing the meals. Staff 2 informed Resident B he would get to him, but Resident B was not getting his meal fast enough. There was an exchange of words about the food not coming fast enough. Resident B stood up and the next thing both were on the ground. Resident B struck Staff 2 first. Staff 2 did strike back. Other staff members intervened and separated the two. Staff 2 was walked to the front of the building. She did not know what to do. She indicated there were no abuse in-services provided to staff after the incident. During an interview, on 11/28/23 at 12:22 p.m., QMA 5 indicated she was passing medications in the front of the facility, and she heard arguing. She walked to the dining room and observed both		*and abuse in assisted living by January, 31, 2024.* *Executive Director will monitor for any recurrence of potential abuse cases whether prompted by residents or team members. Should another instance of any kind occur, all organization policies will be strictly enforced and followed regarding disciplinary action for the team member and potential considerations for the resident to ensure the safety of all residents.* By what date the systemic changes will be completed. January 30, 2024.	

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	men on the floor. Staff 2 was on top of Resident B. Another resident was trying to separate the two men. She asked the resident to leave and saw Staff 2 on top of Resident B. Resident B was punching Staff 2. Staff 2 had Resident B pinned to the floor. When she first observed the altercation, she thought it was two residents, then she realized it was the staff member fighting with Resident B. A current facility policy, titled "ALLEGATIONS OF ABUSE/NEGLECT/EXPLOITATION POLICY AND PROCEDURE," dated as last revised on 09/01/22 and received from the Executive Director on 11/28/23 at 10:20 a.m., indicated the facility "...has zero tolerance for abuse, neglect or exploitation of its residents...." A current facility policy, titled "INDIANA RESIDENT RIGHTS," undated and received from the Executive Director on 11/28/23 at 12:53 p.m., indicated "...You have a right to the following...Freedom from sexual, physical, mental abuse, verbal abuse, corporal punishment, neglect and involuntary seclusion...." This State Residential Finding relates to Complaint IN00421484.			