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	02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RITTENHOUSE VILLAGE AT PORTAGE	6235 STERLING CREEK RD PORTAGE, IN 46368

(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 IN00399437. Complaint IN00399437 - Substantiated. State deficiency related to the allegations is cited at R0090. Survey date: 2/1/23 Facility number: 012396 Residential Census: 81 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on 2/6/23.	R 0000	The following is the plan of correction for the Rittenhouse Village at Portage in regards to the statement of deficiencies dated February 1, 2023. 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. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.	
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual			

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

Kristin Pawlak | Executive Director | 03/23/2023

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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	occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports			

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	available for inspection to any member of the public upon request Based on record review and interview, the facility failed to ensure the facility's abuse policy was followed, related to not reporting an allegation of misappropriation of resident property to the Indiana Department of Health (IDOH) and not thoroughly investigating the allegation of misappropriation for 1 of 2 residents reviewed for abuse. (Resident C) Finding includes: During an interview on 2/1/23 at 10:31 a.m., the Administrator indicated Resident C had reported $150 was missing from her apartment. The Police were notified of the allegation. The allegation had not been reported to the IDOH. A few staff had been asked about the money. The resident had not accused the staff of taking the money and we encouraged her to make a police report. During an interview on 2/1/23 at 1:05 p.m., Resident C indicated there had been $150 missing from her wallet on 1/9/23. She had received the money as a Christmas present and had kept the money in her wallet in her purse. She had reported the missing money to the Administrator and had voiced she thought the staff had been in her room and took the money. She indicated the Administrator informed her it would not have been any staff members as they were all honest and had worked at the facility for a long time. The facility had notified the local Police Department, who had taken statements and informed her the information would be given to a Detective and the Detective would come out to the facility. The Detective had not yet come to the facility to speak to her.	R 0090	1.What corrective actions will be accomplished for those residents found to have been affected by deficient practice? Residents, family, and staff trained on reporting requirements. Executive Director to check with all Residents to ensure any reporting Incidents that were needed, did get completed. 2.How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be effected. All residents and families trained on ISDH reporting requirements and encouraged to report to the executive director or director of nursing. 3. What measures will be put into place or what systematic changes the facility will ensure that the deficient practice does not occur? All staff will be retrained on	03/22/2023

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	Resident C's record was reviewed on 2/1/23 at 1:58 p.m. The diagnoses included, but were not limited to, diabetes mellitus and kidney disease. An Assessment/Service Plan, dated 2/3/22, indicated she was oriented to person, place, and time and was able to communicate clearly. An undated facility policy, titled, "Allegations of Abuse/Neglect/Exploitation", received from the Administrator on 2/1/23 at 10 a.m., indicated misappropriation of resident property was a definition of abuse. The Administrator or designee was to conduct and document a thorough investigation. Allegations were to be reported by the facility to the IDOH within twenty-four hours. A detailed and accurate investigative report was to be completed within 72 hours of the incident. This Residential tag relates to Complaint IN00399437.		unusual occurrence policy and reporting policy and continue education annually. How will the corrective actions be monitored to ensure the deficient practice will not recur, what quality assurance programs in place? Executive Director or designee will ask managers 3 times a week for 6 weeks if an unusual occurrence has occurred to ensure reporting was not missed. Executive Director will ask 3 residents per week for the next 6 weeks if any unusual occurrence needs to be reported	