

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>011274</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>03/28/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>RIVERWALK COMMUNITIES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>401 S.E. 6TH STREET</b> <b>EVANSVILLE, IN 47713</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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) COMPLETE DATE
{R 000}	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a Post Survey Revisit (PSR) to Investigation of Complaint IN00397975 completed on December 30, 2022.</p> <p>Complaint IN00397975- Corrected</p> <p>Survey dates: March 28, 2023.</p> <p>Facility number: 011274</p> <p>Residential Census: 95</p> <p>Riverwalk Communities was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00397975.</p> <p>Quality review completed on March 29, 2023.</p>	{R 000}		

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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