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	05/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVERWALK COMMUNITIES	401 S.E. 6TH STREET EVANSVILLE, IN 47713

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00405259 and IN00405141. Complaint IN00405259-No deficiencies related to the allegations are cited. Complaint IN00405141-No deficiencies related to the allegations are cited. Survey dates: May 3, 4, 5, 8, 2023 Facility number: 011274 Residential Census: 90 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 16, 2023.	R 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective June 27, 2023.	
R 0041 Bldg. 00	410 IAC 16.2-5-1.2(o)(4) Residents' Rights - Deficiency (4) The facility shall develop and implement policies for investigating and responding to complaints when made known and grievances made by: (A) an individual resident; (B) a resident council or family council, or both; (C) a family member; (D) family groups; or (E) other individuals. Based on interview and record review the facility failed to ensure an investigation and response were completed for resident filed grievances for 2 of 8 residents. (Resident 3, Resident 4)	R 0041	The corrective action taken immediately for the residents found to have been affected by the deficient practice is that an	06/27/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Becky Ougel	Director of Nursing	05/30/2023

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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	Finding includes: 1. During an interview on 5/3/23 at 1:10 P.M., Resident 3 indicated a cell phone had gone missing from their room. Staff had been notified through a grievance form, and had not issued resolution related to the grievance. During an interview on 5/3/23 at 2:27 P.M., a grievance form from 1/5/23 was reviewed. The form indicated "[Resident name] states his phone disappeared while he was in the hospital. Someone had been in his room, they left laundry in his recliner. Wants to know if phone is going to be replaced by facility." The bottom of the form indicated the following response " Refer to IHCC [integrated healthcare community coordinator] for replacement." During an interview on 5/3/23 at 2:27 P.M., the DON (Director of Nursing) indicated Resident 3's phone may have been grabbed with laundry and had been replaced. During an interview on 5/4/23 at 8:27 A.M., Resident 3 again confirmed nobody had followed up with the grievance nor replaced the missing phone. During an interview on 5/4/23 at 2:28 P.M., Housekeeper 25 indicated if a grievance was filed for a lost item it would be looked for, but no phone had been reported lost through laundry services. Documentation of follow up for this grievance and documentation regarding replacement of the phone was requested from the DON and was not provided. 2. During an interview an 5/4/23 at 1:15		investigation was started to determine if phone had been misplaced by staff. Phone was determined to have been accidentally removed from room with laundry. Resident 3 phone replaced by Riverwalk Communities. The corrective action taken immediately for the residents found to have been affected by the deficient practice is that a concern form was filled out and investigation was started. Investigations determined resident did not lose coat as the result of staff or community. Stated in resident agreement facility not responsible for lost or stolen items. Resident how ever was taken shopping for replacement by Life Enrichment Coordinator. The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is Complant/Concern policy updated. Staff educated on policy and how to assist residents with filling out form. The measures that have been put into place to ensure deficient practice recur, Compliant/Concern review added to QA meeting outline. QA meetings to be held 3 times weekly for one week, 2 times weekly for 1 week, then weekly, encouragement of all department's heads attendance.	

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	P.M., Resident 4, indicated his black leather jacket went missing a month after he moved into the facility. Resident 4 indicated he spoke with the previous Social Services Director about the missing jacket, and there was no follow up. Resident 4 indicated he spoke with the Activities Director in March, and again there was no follow up. At that time, Resident 4 indicated he did not know how to fill out a grievance form. During an interview on 5/4/23 at 2:06 PM., Activities Director indicated that she spoke with Resident 4 about the missing jacket. Activities Director indicated housekeeping and laundry were made aware of the missing jacket. During an interview on 5/4/23 at 2:30 P.M., Laundry 14 indicated that she had only been in their position for 3 days and did not know of any missing jacket. On 5/4/23 at 2:40 P.M., during an interview with Housekeeper 25, they knew nothing about the missing jacket, but does remember the resident wearing it when it was colder out side. House keeper 25 indicated they try to find the missing article and even replace if indicated. On 5/5/23 at 9:30 A.M., during an interview with Community Service, they indicated that they have not received any paper work from Activities Director concerning Resident 4's lost jacket. Community Service was not aware of any lost jacket. On 5/5/23 at 11:51 A.M., the DON provided the current policy on complaint/concerns. The policy included, but was not limited to, "Within five business days there will be a written notice of resolution."			

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R 0088 Bldg. 00	410 IAC 16.2-5-1.3(c)(1-2)(d)(1-2) Administration and Management - Noncompliance c) The licensee shall: (1) appoint an administrator with either a: (A) comprehensive care facility administrator license as required by IC 25-19-1-5(c); or (B) residential care facility administrator license as required by IC 25-19-1-5(d); and (2) delegate to that administrator the authority to organize and implement the day-to-day operations of the facility. (d) The licensee shall notify the director: (1) within three (3) working days of a vacancy in the administrator's position; and (2) of the name and license number of the replacement administrator Based on interview and record review, the facility failed to have a licensed administrator. The current facility administrator's license was expired. (Administrator) Finding includes: During the entrance conference on 5/3/34 at 8:35 A.M., the DON indicated the current Administrator's provisional license had expired and he had applied for a renewal. During the record review and interview on 5/3/23 at 2:06 P.M., the Administrator indicated the provisional license had expired on 1/31/23. He indicated the renewal fee was sent on 1/18/23 and he has not received any official notice of renewal. During a record review on 5/4/23 at 12:06 P.M., the Administrator's license was observed on the "Indiana Professional Licensing Agency" website as expired as of January 29, 2023.	R 0088	The corrective action taken immediately, Upper management meeting held to discuss immediate action and determined Current members of management would not be prepared to take Jurisprudence examinations until after July 1, 2023, it was decided that HR would investigate Agency and advertising for temporary Licensed Administrator. The corrective action taken to ensure that no licensed employees fall under the same deficient practice is all licensed personnel listed with expiration dates for license on audit tool. The measures that have been put in place to ensure that deficiencies do not recur, Updated License renewal policy, education provided to staff. Notification Reminders would be provided to	06/27/2023

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	On 5/5/23 at 11:51 A.M., a current policy "Policy License Renewal" dated 3/6/13 indicated "Purpose: It is the policy of Riverwalk that all licensed personnel maintain a professional licence in a good standing with the state of Indiana. 2 Scope. This policy relates to all the personnel that are required to maintain a specific job license...3. It is the responsibility of licensed personnel to renew job specific licensure when due. 4... licensed personnel must renew their license and present Riverwalk... with a job specific license before the expiration of said license..."		anyone within 30 days of expiration date, 2 weeks of expiration date, 1 week of expiration date, if staff member fails to renew license by 1 day of expiration date notice not to return until in good standing would be issued.	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents			

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	effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to provide documentation of staff completing a minimum of 3 hours of dementia-specific training annually for 3 of 5 employee files reviewed (Registered Nurse 5, Qualified Medication Aide 7, Licensed Practical Nurse 9). Findings include: On 5/4/23 at 9:05 A.M., employee files were reviewed. Records indicated the following: Registered Nurse (RN) 5 lacked the 3 hours of dementia-specific training in 2022 or 2023. Qualified Medication Aide (QMA) 7 lacked the 3 hours of dementia-specific training in 2022 or 2023. Licensed Practical Nurse (LPN) 9 lacked the 3 hours of dementia-specific training in 2022 or 2023. On 5/5/23 at 8:07 A.M., the Director of Nursing (DON) indicated that no staff in the facility had any dementia-specific in-services in 2022 or 2023.	R 0120	Corrective action taken immediately, RN 5. QMA 7, LPN9, provided with Relias password and time made available for staff members to complete dementia training. Corrective action taken to ensure that all staff received in-service according to policy, Audit of staff members requiring dementia training completed, these staff members provided with training via Relias. The corrective action taken to prevent deficient practice, In service policy updated Facility purchased Relias along with electronic charting module, scheduled in-services per staff members job, assigned in-services scheduled in program, with instruction on use of Relias.	06/27/2023

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	On 5/5/23 at 11:51 A.M., the DON provided a current policy on in-services, last updated on 3/5/2013. The policy indicated facility to provide "in-services throughout the year ...to maintain regulatory compliance".			
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record			

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	of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the facility failed to screen employees for tuberculosis annually for 3 of 5 employee files reviewed (Registered Nurse 5, Qualified Medication Aide 7, Licensed Practical Nurse 9). Findings include: On 5/4/23 at 9:05 A.M., employee records were reviewed. Records indicated the following: Registered Nurse (RN) 5 lacked a tuberculosis (TB) screen dated in 2022 or 2023. Qualified Medication Aide (QMA) 7 lacked a TB screen dated in 2022 or 2023. Licensed Practical Nurse (LPN) 9 lacked a TB screen dated in 2022 or 2023. On 5/5/23 at 8:17 A.M., the Director of Nursing (DON) indicated that she didn't have current TB screens for RN 5, QMA 7, or LPN 9. On 5/5/23 at 9:42 A.M., the DON provided the current policy on TB, updated 11/2012. The policy indicated a staff requirement of an "annual assessment for signs and symptoms of tuberculosis".	R 0121	The immediate action taken is RN 5, QMA 7, LPN 9, TB screen completed. The corrective action takento prevent deficient practice affecting other staff members is a audit was completed to identify staff members needed TB screening completed. The measures taken to prevent deficiencies from recurring is all staff will be scheduled to complete TB screening the 4th month of every year.	06/27/2023
R 0214	410 IAC 16.2-5-2(a) Evaluation - Deficiency			

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Bldg. 00	(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to ensure semiannual evaluations were completed or signed by the resident or responsible party for 5 of 8 residents reviewed (Resident 2, Resident 4, Resident 5, Resident 6, Resident 8). Findings include: 1. On 5/3/23 at 10:25 A.M., Resident 2's clinical record was reviewed. Resident 2 was admitted on 12/27/2017. The record lacked a signed semiannual evaluation. 2. On 5/3/23 at 2:00 P.M., Resident 8's clinical record was reviewed. Resident 8 was admitted on 1/13/22. A signed semiannual evaluation was completed 6/15/22. The record lacked a signed semiannual evaluation dated after 6/15/22. 3. On 5/4/23 at 2:00 P.M., Resident 4's clinical record was reviewed. Resident 4 was admitted on 5/2/22. The record lacked a signed semiannual evaluation. 4. On 5/3/23 at 10:00 A.M., Resident 6's clinical record was reviewed. Resident 6 was admitted 9/21/18. The most recent Evaluation for Residential Care was dated 2/11/22. The top of the form indicated "An Evaluation for Residential Care is required for initial [and] semi-annual review [and] upon known substantial change in condition or more often at the resident's or facility's request". The clinical record lacked an evaluation after 2/11/22.	R 0214	The corrective action immediately taken for the residents found to have been affected by the deficient practice is Level of Care/Service plan assessment completed on Resident's 2,8,4,6,5, in the new computer system Point Click Care. The corrective action taken for all residents found to have been affected by the same deficient practice is a chart audit completed to determine need and Level of Care/Service Plans assessment completed in Point click care. The measure taken to prevent deficient practice from recurring is Level of Care/Service plan assessment completed, then are scheduled out to populate every 6 months in point click care. Reports will be completed by nurse management weekly to ensure they are completed.	06/27/2023

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	5. On 5/3/23 at 1:15 P.M., Resident 5's clinical record was reviewed. Resident 5 was admitted 12/8/20. The record lacked an Evaluation for Residential Care upon admission or semi-annually thereafter. On 5/4/23 at 10:05 A.M., the Director of Nursing (DON) indicated semiannual evaluations should be done every 6 months and signed by the resident or responsible party. On 5/5/23 at 11:51 A.M., the DON provided a policy titled Policy Assessment Person Centered, last updated 11/2012. The policy indicated "psychosocial and physical assessment completion at least every six months".			
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to ensure that resident weights were obtained as ordered for 4 of 8 residents reviewed. The records for 4 of 8 residents lacked completed weights as per MD(Medical Doctor) orders.	R 0216	The corrective action immediately taken for residents found to have been affected by the deficient practice, Resident 2,4,6,8 electronic chart is update and	06/27/2023

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	(Resident 2, Resident 4,Resident 6, Resident 8). Findings include: 1. On 5/3/23 at 11:45 A.M., Resident 4's clinical record was reviewed. Current physician's orders included but were not limited to: Monitor resident vitals and weight quarterly, report abnormal findings to nurse every day shift ever 3 months, Dated 2/23/23. A Resident Weight Record form indicated that Resident 4's weights were last recorded July of 2022 and lacked any further documentation of weights.2. On 5/3/23 at 10:25 A.M., Resident 2's clinical record was reviewed. A physician's order initiated 7/27/22 indicated to obtain weights monthly. The most current service plan, dated 10/9/21, indicated that Resident 2 was to be weighed according to the physician's order. The record lacked documented weights for the last 6 months. 3. On 5/3/23 at 2:00 P.M., Resident 8's clinical record was reviewed. A physician's order initiated 7/27/22 indicated to obtain weights monthly. The most current service plan, dated 1/13/22, indicated that Resident 8 was to be weighed according to the physician's order. The record lacked documented weights for the last 6 months.4. On 5/3/22 at 10:00 A.M., Resident 6's clinical record was reviewed. Current physician's orders included, but were not limited to: Weight every month, dated 7/27/22. Resident 6's medication administration record (MAR) from 8/2022 through 5/2023 lacked documentation that a weight had been obtained for Resident 6 as ordered.		document vitals tab in Point Click Care. The corrective action taken for all other residents determined to be affected by the same deficient practice is an audit of all residents completed to ensure that all vitals are documented according to MD orders. Orders are then transcribed into electronic chart and scheduled to populate per order. The measure taken to prevent deficient practice from recurring is, all orders will be scheduled in Point Click Care to according to MD orders, missing orders report will be reviewed by nurse management weekly to ensure documentation is being completed.	

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	An Evaluation for Residential Care form indicated the most recent weight that was obtained for Resident 6 was on 2/11/22. During an interview on 5/4/23 at 11:40 A.M., Licensed Practical Nurse (LPN) 3 indicated staff were told they were not required to obtain resident weights. On 5/4/23 at 10:05 A.M., during an interview with the DON, indicated the facility did not have a policy on weights currently. The facility policy would be to do the weights monthly, but are transitioning to quarterly. The facility has asked MD's if the they wanted the weights monthly as they transfer to the new system, but if previously ordered as monthly the physician order should be followed.			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy			

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	of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure service plans were completed or signed by the resident and/or responsible party for 6 of 8 residents reviewed. (Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 8) Findings include: 1. On 5/3/23 Resident 3's clinical record was reviewed. Resident 3 was admitted on 2/3/20. The clinical record lacked a signed service plan since 9/1/21. The clinical record lacked a service plan care conference since 3/3/21.2. On 5/4/23 at 11:45 A.M., Resident 4's clinical record was reviewed. Resident 4 was admitted on 5/2/22. The service plan was completed on 5/2/22 but lacked the resident's signature.3. On 5/3/23 at 10:25 A.M., Resident 2's clinical record was reviewed. Resident 2 was admitted on 12/27/17. A signed service plan was completed on 10/9/21. The record lacked a signed service plan since 10/9/21. 4. On 5/3/23 at 2:00 P.M., Resident 8's clinical record was reviewed. Resident 8 was admitted on 1/13/22. A signed service plan was completed on 1/13/22. The record lacked a signed service plan since 1/13/22.5. On 5/3/23 at 10:00 A.M., Resident 6's clinical record was reviewed. The most recent	R 0217	The Corrective action immediately for residents found to have been affected by the deficient practice is Level of Care/Service plan assessment completed on Resident's 3,4,2,8,6,5, in the new computer system Point Click Care. The Service Plan was then reviewed and signed by residents. The corrective action taken for all other residents found to have been effected by the same deficient practices are, chart audit completed to ensure that all residents have signed service plan within 6 months of compliance date. All Service plans updated and signed to Point Click Care electronic record. The measure taken to prevent deficient practice moving forward is, all residents Level of Care/ Service plan will populate every 6 months for review and resident signature, each floor having its own assigned month to be documented in Point Click Care. Nurse Management will run	06/27/2023

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	service plan care conference was dated 5/19/21. The clinical record lacked documentation of an actual service plan for Resident 6. 6. On 5/3/23 at 1:15 P.M., Resident 5's clinical record was reviewed. The most recent service plan care conference was dated 2/7/22. The clinical record lacked documentation of an actual service plan for Resident 5. During an interview on 5/4/23 at 10:05 A.M., the Director of Nursing (DON) indicated service plans should be completed upon admission, and every six months thereafter. She indicated the service plans were to be signed by the resident as well. On 5/5/23 at 11:51 AM the DON (Director of Nursing) provided the current policy on service plans. The policy indicated "Service plans will be completed semi-annually and upon a known resident's substantial change in condition or more often at the resident's or facility's request ... The agreed upon service plan shall be signed and dated by the resident or guardian/resident representative."		service plan report weekly to ensure compliance.	
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on observation,interview, and record review, the facility failed to ensure that medications were given as prescribed for 1 of 5 residents for observed for medication administration. A medication cup with loose pills was observed in a medication cart. (Resident 10).	R 0247	Immediate action taken to correct deficient practices Resident 10, Resident and MD notified of med error, med error report completed, staff monitor for Adverse drug reaction.	06/27/2023

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	Findings include: On 5/4/23 at 8:45 A.M., during an observation of the medication pass of the fifth floor medication cart, there was a medication cup with a resident's room number (Resident 10) sitting in the medication cart. There were 9 pills in the medication cup. At that time, QMA 21 indicated that the medications were not suppose to be in the cart and must have been missed. On 5/4/23 at 8:50 A.M., Resident 10's clinical record was reviewed. Diagnosis include, but are not limited to, hypertension and dementia. Physician orders include, but not limited to: Meloxicam 7.5 mg (milligrams) 1 tablet by mouth daily, Pantopramzoe 40 mg 1 tablet by mouth daily, Tradjenta 5 mg 1 tablet by mouth daily, Glipizide 5 mg take 1/2 tablet by mouth daily, Finasteride 5 mg 1 tablet by mouth, Famotidine 20 mg 1 tablet by mouth twice daily, Gabapentin 100 mg 1 capsule by mouth twice daily, Tamsulosin 0.4 mg 1 capsule by mouth twice daily, and Metoprolol ER 25 mg 1 tablet by mouth daily. On 5/4/23 at 9:00 A.M., Resident 10's MAR (Medication Administration Record) for the current month indicated on 5/4/23 the 6:00 A.M. medications had been given. At that time LPN (Licensed Practical Nurse) 3 indicated that the pills left in the medication cup from earlier that morning were Resident 10's 6 A.M. medications and had not been given: Meloxicam 7.5 mg Pantoprazole 40 mg Tradjenta 5 mg Glipizide 5 mg 1/2 pill Finasteride 5 mg		Corrective action taken to ensure no other residents are affected by the same practice audit of MAR to ensure all residents received medications or documentation of missed dose in place. Educated staff on medication policy and procedures. The measures taken to ensure deficient practices don't recur is cart and MAR Quality assurance tool created to aid in review of deficiencies, Audit to be completed every shift for 7 days, daily for 7 days, three times in 7days, twice in 7days, and weekly. Policy on medication errors and administration updated all staff educated. Will discuss in weekly QA meetings weekly.	

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	Metoprolol ER 25 mg Famotidine 20 mg Gabapentin 100 mg Tamsulosin 0.4 mg During an interview on 5/5/23 at 2:00 P.M., the DON indicated if a medication dose was missed, the nurse would need to notify the physician On 5/4/23 at 1:00 P.M. a current policy "Medication Administration" dated 10/25/19 indicated " All medication is to be administered as prescribed... the nurse administering the medication is to initial the resident's medication record in the space provided for that drug and schedule time off administration... Medication errors/omissions with drug.... shall be reported to the attending physician..."			
R 0270 Bldg. 00	410 IAC 16.2-5-5.1(c)(1-3) Food and Nutritional Services - Deficiency (c) The facility must meet: (1) daily dietary requirements and requests, with consideration of food allergies; (2) reasonable religious, ethnic, and personal preferences; and (3) the temporary need for meals delivered to the resident ' s room. Based on observation, interview, and record review, the facility failed to ensure diets were followed as ordered for 1 of 8 resident records reviewed. A resident was not provided with a mechanical soft diet as ordered. (Resident 9) Finding includes: During an interview on 5/4/23 at 11:15 A.M., the Kitchen Manager indicated all residents were served a regular diet with no modifications.	R 0270	The corrective action taken immediately was resident 9 diet order updated and dietary notified to provide mechanical soft diet. The corrective action taken to prevent any other resident's from being effected by the same deficient practice is diet orders updated in Point Click Care electronic charting module, dietary management provided with user name and password to verify all	06/27/2023

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	On 5/4/23 at 1:24 P.M., Resident 9's clinical record was reviewed. Resident 9 was admitted 11/14/22. Diagnosis included, but were not limited to, dementia and dysphasia (difficulty swallowing). Current physician orders included, but were not limited to: regular diet mechanical soft, dated 11/15/22. A nutrition services progress note, dated 11/14/22 indicated the following: "Resident admitted to [facility name] on [unreadable] diet mech [mechanical] soft. Per DON [Director of Nursing] AL [Assisted Living] does not offer that diet ... [resident name] has issues chewing [and] swallowing her food per my observation ..." During an interview on 5/4/23 at 2:00 P.M., Resident 9 indicated she had trouble eating, and could only eat soft foods. She indicated she could chew most things, but could not swallow a lot of foods as she chokes easily. At that time, Resident 9 was observed with no teeth. During the survey, the following confidential interviews were obtained: I have seen her (Resident 9) eat, and she had trouble with some foods that were hard, and could only eat soft foods. I worried for (Resident 9) because she could not eat what was given to her, and had trouble swallowing. I feared she would choke on her food while in her room eating alone. I also worried that she was losing weight due to not being able to eat everything on her plate. During an interview on 5/4/23 at 2:30 P.M., the DON indicated if a resident wished to be admitted		diet orders. The corrective action taken to prevent deficient practice from recurring is admission agreement updated to include altered diet, staff education provided. Point click care orders report for dietary daily for a week, then three times a week, twice weekly, weekly then communication provided on every admission utilizing dietary dash board.	

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	to the facility with or developed a need for a modified diet, they would be referred to a nursing home, or they were asked to sign a dysphasia waiver as a stipulation of admission or staying in the facility. The DON indicated she did not accept any resident that required a modified diet, and had provided the kitchen manager with a statement that they did not provide modified diets. At that time, the DON indicated the facility did not have a policy for providing modified diets. During an interview on 5/5/23 at 11:53 A.M., the DON indicated it was the facility's policy to follow physician orders as ordered. A current undated Menus policy was provided 5/5/23 at 1:30 P.M., and indicated "Menus will be planned that meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board ... Menus shall be adjusted to meet individual caloric and nutrient-intake needs of the residents ... Menus for regular and therapeutic diets are written at least two (2) weeks in advance ..."			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, record review, and interview, the facility failed to ensure food was stored appropriately for 2 of 2 kitchen observations. Food was not labeled in the dry storage area or refrigerator, pitchers of liquid were not labeled in the kitchen area, and kitchen equipment was damaged. (kitchen)	R 0273	1.The corrective action taken immediately was that the bandage was removed and disposed of and area was sanitized. Hand washing measures were observed. The corrective action taken to prevent other items from falling	06/27/2023

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	Findings include: On 5/3/23 at 8:38 A.M., the following was observed in the kitchen: A used bandage was sitting on the counter just to the right of the dishwasher door. The door of the ice machine was cracked on both sides in the corners, with the exposed areas sharp. A white and brown flaky substance was observed on the ledge of the ice machine just above the lid. A black and brown coffee ground substance was observed at the top of the tea maker by the filter holder. Five full pitchers of brown liquid were observed on a rolling cart with no labels. Two full pitchers of brown liquid were observed on another rolling cart with no labels. The following was observed in the white refrigerator by the warmer: Two bags of stir fry vegetables in the freezer with frost inside the bags covering the food. Three blocks of sliced cheese with no labels. One container of strawberries with a white fuzzy substance on two of them. The container was not labeled. A silver pan containing sliced pickles with no label. A silver pan containing assorted fruit with no label. A silver pan containing shredded cheese with no label. The following was observed on the dry storage racks: One bag of nilla wafers, open with no label. A clear tub of rice with no visible label. A clear tub of pasta with no visible label. A clear tub of beans with no visible label.		under same deficiency was that an Audit Tool was put in place to inspect all kitchen surfaces each shift to ensure no other unsanitary items were present and that areas were sanitized. 2. The corrective action taken immediately was to contact CRS to have them come out and assess and repair the door or see if a replacement door is needed. A sign was displayed indicating sharp corners. The corrective action taken to prevent other items from falling under same deficiency was that all kitchen equipment was inspected to ensure no other equipment was damaged. Audit tool was put in place to document any items needing repair. 3. The corrective action taken immediately was that dietary staff cleaned and sanitized the ice machine and tea machine. The corrective action taken to prevent other items from falling under same deficiency was that dietary staff inspected all surfaces to ensure they were cleaned and free of residue. Audit Tool put in place to inspect after each shift to ensure surfaces were clean and sanitized. 4. The corrective action taken immediately was that pitcher's contents were disposed of and pitchers were cleaned, sanitized, and labeled. Action to prevent other items from	

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	One bottle of chocolate sauce with the date 12/1/22 written on it. The expiration date on the original packaging label was 10/1/21. A bottle of Worcestershire sauce, open with no label. A 50 ounce can of cream of mushroom with a half-dollar size dent at the top rim. The following was observed in the walk-in refrigerator: A milk carton, used washcloth, and a water bottle were on the floor, under the bottom shelf. Three bags of lettuce (one was open) with no labels. Three closed bags of broccoli with no labels. Five bags of shredded cheese (one was open) with no labels. A crate of milk cartons was sitting on the floor. A crate of onions was sitting on the floor. A used bag of icing was observed on the top shelf with the tip covered in plastic wrap and no label. A bag of a light orange substance with no label. A box of bacon open to air. On 5/4/23 at 11:01 A.M., the following was observed in the kitchen: The door of the ice machine was cracked on both sides in the corners, with the exposed areas sharp. A white and brown flaky substance was observed on the ledge of the ice machine just above the lid. A black and brown coffee ground substance was observed at the top of the tea maker by the filter holder. Three full pitchers of brown liquid were observed on a rolling cart with no labels. The following was observed on the dry storage racks: A clear tub of rice with no visible label.		falling under the same deficiency was to inspect all pitchers of liquid in the kitchen area to ensure all were labeled. Audit Tool put in place to inspect pitchers of liquid to ensure they are labeled each shift. 5. The corrective action taken immediately was that all expired items were disposed of. All items that were not labeled were discarded. Action to prevent other items from falling under same deficiency was that Audit Tool was created to inspect all items in white refrigerator. Ensured all items were labeled and any expired or unlabeled items were disposed of. 6. The corrective action taken immediately was that all items not labeled were labeled. Expired items were disposed of. Action to prevent other items from falling under same deficiency was that Audit Tool was put in place to inspect all items on dry storage racks to ensure they were labeled each shift. Unlabeled items were labeled. 7. The corrective action taken immediately was that dented can was disposed of. Action taken to prevent other items from falling under the same deficiency was that Audit Tool was put in place to inspect other cans. Ensured no other dented cans were present. 8. The corrective action taken	

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	A clear tub of pasta with no visible label. A clear tub of beans with no visible label. A 50 ounce can of cream of mushroom with a half-dollar size dent at the top rim. The following was observed in the walk-in refrigerator: Two closed bags of lettuce with no labels. Three closed bags of broccoli with no labels. Four closed bags of shredded cheese with no labels. A bag of a light orange substance with no label. A box of bacon open to air, with a silver bowl sitting on top of it with a red liquid substance in the bottom of it. During an interview on 5/4/23 at 11:13 A.M., the Kitchen Manager indicated all food in the kitchen should have been labeled with the date it was opened, and all expired items needed to be disposed of. She indicated dented cans were supposed to be sent back for credit, and not used. A current undated Food Receiving and Storage policy, provided 5/5/23 at 1:30 P.M., indicated "Food Services, or other designated staff, will maintain clean food storage areas at all times ... Dry food items are to be labeled and dated when opened ... Dry foods that are stored in bins will be removed from original packaging, labeled and dated ... All foods stored in the refrigerator or freezer will be covered, labeled and dated ... All food items will be dated upon receipt"		immediately was to remove milk carton and water bottle and dispose of. Washcloth was removed. Action taken to prevent other items from falling under same deficiency was that an Audit Tool was put in place to inspect walk-in refrigerator each shift for items needing to be removed and discarded. 9. The corrective action taken immediately was that all items that were not labeled were discarded. Action to prevent other items from falling under same deficiency was that Audit Tool was created to inspect all items in walk-in refrigerator per shift. Ensured all items were labeled, dated, and any open boxes of food were covered and sealed. 10. The corrective action taken immediately was that items observed were removed from the floor. Action to prevent other items from falling under same deficiency was that Audit Tool was put in place to inspect floor of walk-in refrigerator each shift to ensure no other items were sitting on the floor in the walk-in refrigerator. The corrective action put in place to ensure deficient practice does not recur in the future is that dietary staff were in-service on Infection Control Policy and Handwashing/Hand Hygiene.	

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			Perishable Food Storage Policy, Dry Food Storage Labeling Policy, Dented Can Policy, was put in place staff educated. Quality Assurance Tool was put in place for Dietary Manager to inspect each shift for 7 days, then daily for 7 days, then 3 times weekly for 7 days, then 2 times weekly for 7 days, then weekly for 7 days, then monthly to ensure Infection Control Policy and Handwashing Policy is followed. The Dietary Manager will keep a binder with a record of daily/weekly checks.	
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on observation,interview, and record review, the facility failed to have a written policy and procedure for medication record keeping including narcotic count for 4 of 4 days of the survey.	R 0298	The corrective action taken immediately is narcotic count reviewed by 2 nurses, Contracted pharmacy contacted to review policy for narcotic count. The corrective action taken to	06/27/2023

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	Finding includes: On 5/4/23 at 10:10 A.M., the narcotic book on the 6th floor was reviewed a shift on 5/2/23 lacked a signature. On 5/4/23 at 10:15 A.M., a form tapped to the front of the narcotic book was provided by RN 6, indicated " You may not leave unit you have counted and signed the Narcotic Sheets and exchanged keys." During an interview on 5/4/23 at 10:30 A.M., the (Director of Nursing) DON indicated the narcotic count should be done and documented at the change of each shift. During at interview on 5/5/23 at 1:59 P.M., DON indicated there was no current written policy but the policy for the facility, was the oncoming nursing staff will do the narcotic count with the narcotic binder present and exchange keys with the off going nurse. If there is any discrepancy with the narcotic count the DON should be called immediately, regardless of the key exchange.		prevent deficient practice from recurring is narcotic count policy implementation, staff education and cart audit tool reviewed every shift for one week, daily for a week, three times a week, twice a week, then weekly.	
R 0306 Bldg. 00	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of.			

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	05/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVERWALK COMMUNITIES	401 S.E. 6TH STREET EVANSVILLE, IN 47713

(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
	(6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on observation, record review, and interview, the facility failed to ensure proper storage of medication in 5 of 5 medication cart. (Fifty one unlabeled pills in 1 of 2 carts of the 400 and 500 Halls,10 unlabeled pills in cart 3 of the 600 hall, 5 unlabeled pills of cart 2 of 600 hall, and 10 unlabeled pills in cart 1 of 300 hall) Findings include: On 5/4/23 at 7:43 A.M., during an observation of the 400 and 500 Halls medication carts there were loose pills found in several drawers of the carts: 2 yellow capsules TP #102 1 oblong pill AP0 1 small white round pill #1 1 yellow scored pill # 798 1 large white pill scored PIll 434 1 orange round pill #022 1 large oblong pill G #433 1 large orange pill #44 227 2 capsule ZC42 2 blue green capsule #03 1 orange capsule IP #103 4 large white rounds pills PLIV #434 1 white round pill ZC #42 1 small round white pill #606 1 small white pill #1285 1 oblong yellow pill #152 1 scored yellow no number 1 round pill # 798 1 large oblong orange no number 1 flat small white pill #06	R 0306	Ther corrective action taken immediately is medications were disposed of in Drug buster compound. The corrective action taken to prevent recurring of deficient practices is contracted pharmacy policies updated, staff education, and nurse management to conduct cart audits, every shift for one week, daily for one week, three times a week for one week, two times a week for one week, then weekly.	06/27/2023

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		A. BUILDING 00 B. WING	05/08/2023

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	1 small flat white 1235 1 white large white CZ 4c 1 small white round no number 1 small round pill # 253 1 reddish oblong #09 1 small blue round pill M #1010 ½ white pill no number 2 ¼ pills white no numbers 1 oblong white ATV #40 2 small round white pills no number 2 scored white round pills PLIV #43B 1 yellow round pill #40 1 orange round pill no number 1 large clear pill no number 1 small square pill no number 1 yellow capsule TP #102 1 oblong yellow pill #152 1 small oblong pill N #31 1 blue peach capsule G #232 2 orange round pills 022 1 brown oblong pill #355 1 yellow oblong pill #003 1 oblong white pill N #10 1 small white round scored pill #00 1 oblong white pill AT #5 1 small round peach pill U #220 1 red capsule TEVA #3147 1 flat white round pill #40 1 white capsule IP # 101 1 multi colored round pill no number 1 small white pill no number Cart #3 for 600 HALL 9:11 A.M. 3 ½ white pills no number 1 larger orange pill H #40 1 large whine oblong pill no number 1 small pale yellow oblong pill #25 1 yellow pill EP #127 1 oblong white pill A #P0			

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		A. BUILDING 00 B. WING	05/08/2023

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	1 large peach pill no number 1 scored white pill A #50 2 small white pills #25 1 white pill #209 Cart #2 600 Hall 1 small yellow round pill no number 1 large clear yellow pill no number 1 oblong white pill unable to read number 1 orange oblong pill LU 1 white oblong #4 Cart #1 for 300 Hall 2 small red pills #10 1 large clear pill no number 1 two tone with brown and tan capsule TEVA 1 oblong white pill H #25 1 oblong white pill # 252 2 white round scored pills #44-104 1 large oblong white pill ATS 1 large round pill G #10 On 5/4/23 at 8:15 A.M., during an interview with QMA 21 there are to be no loose pills in the medication carts, and if found loose pills are placed in a solution called Drug Buster where it will be dissolved. QMA 21 indicated they would also tell the nurse that the medication was found and disposed of QMA 21 also indicated that medication carts should be looked at by the third shift. During an interview on 5/4/23 at 9:23 A.M., QMA 17 indicated they try to clean the carts for the 300 and 600 halls at least 2 times a week. During an interview on 5/5/23 at 1:40 P.M., the DON indicated the facility did not have a policy			

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	related to loose pills but staff should dispose of any loose pills observed in the medication carts.			