STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERWALK COMMUNITIES LLC	401 SE SIXTH ST EVANSVILLE, IN 47713

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R000000	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00151767 and IN00152645. Complaint Numbers: IN00151767- Substantiated. No deficiencies related to the allegation are cited. IN00152645- Substantiated. State deficiencies related to the allegation are cited at R297. Survey dates: July 23, 24, 28, 2014 Facility number: 011274 Provider number: 011274 AIM number: N/A Survey team: Anna Villain, RN TC Barbara Fowler, RN Diane Hancock, RN Denise Schwandner, RN 7/23, 7/24/14 Diana Perry, RN 7/23, 7/28/14 Census bed type: Residential: 98 Total: 98 Census Payor type: Medicaid: 91 Other: 7	R000000	By submitting the enclosed material 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 corrections be considered our allegation of compliance effective August 28, 2014 to the state findings of the State Residential Licensure and Complaints survey conducted on July 23, 24, and 28, 2014.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	Total: 98 Residential Sample: 10 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5. Quality review completed on July 29, 2014 by Jodi Meyer, RN			
R000041	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 the facility followed their policy for investigating and responding to resident complaints, for 1 of 1 resident with a complaint about another resident, in the total sample of 10. (Resident #68) Finding includes: On 7/28/14 at 11:35 a.m., Resident #68 and a family member reported that on	R000041	The corrective action taken for those residents found to have been affected by the deficient practice is that the complaint/concern reported by the resident identified as resident #68 was addressed prior to survey. No further complaints/concerns have been expressed by this resident to facility staff. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have been	08/28/2014

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	6/26/14 [Thursday], Resident #48 had told LPN #5 he was going to "get this resident and get her good." She indicated she and the other resident had argued during a resident council meeting that date. According to Resident #68, LPN #5 called the Director of Nurses (DoN) and was told the issue would be addressed the following Monday. The resident indicated nothing was ever addressed the following week. The next weekend, Resident #48 allegedly made threatening comments about Resident #68 to another resident. That was allegedly reported to the Assistant Director of Nurses, who indicated they would address the problem on the following Monday. The resident indicated nothing was addressed that week, so she approached the Administrator. Resident #68 indicated the Administrator, DoN, Resident #48, and her did meet. Resident #48 denied any threats or comments about the other resident, apologized for anything that might have upset her, and indicated he would never hurt her. She indicated she avoided him the best she could until the resident council meeting on 7/24/14. They got into an argument during that meeting and the Activity Director had to intervene and told them it was not the time or the place.		interviewed to determine if there are any other complaints/concerns that have not been investigated by facility staff. No other complaints/concerns have been reported by the residents.The measures that have been put into place to ensure that the deficient practice does not recur is that Administration has reviewed the policy on Compliment/Concerns. A full staff inservice has been scheduled to review this policy. This policy will also be re-distributed to facility residents. The corrective action taken to monitor to assure compliance is that a Quality Assurance tool has been developed and implemented to ensure that all complaints/concerns have been thoroughly investigated and resolved in a timely manner. This tool will be completed by Administrator or designee weekly for four weeks, then monthly for three months, then quarterly for two quarters. The outcome of these tools will be reviewed at the facility's Qualilty Assurance Meetings to determine of any additional action is warranted.	

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	The Administrator and DoN were interviewed on 7/28/14 at 11:50 a.m. They indicated they had gotten the residents together, that Resident #48 had denied any threatening comments and had apologized to the resident. Resident #68 had been rude and sarcastic towards Resident #48 and refused to accept the apology. The DoN indicated LPN #5 had called her the evening after the 6/26/14 resident council meeting. She said the LPN had reported Resident #48 had been very angry at Resident #68 and had said he "was going to get her." The Administrator, DoN, and Activity Director were interviewed on 7/28/14 at 12:15 p.m. The Activity Director indicated Resident #68 had come to the 6/26/14 resident council meeting and started publicly blaming Resident #48 for things; he was embarrassed and angry, but she heard no threats. The DoN indicated Resident #68 never reported being threatened directly, it was all hearsay from LPN #5. The DoN indicated she had never received a statement from LPN #5, but she had told her Resident #48 was angry and upset. There was no indication any other staff or residents were interviewed as part of an investigation into the complaints from Resident #68.			

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	The Administrator provided typewritten notes from the Director of Nurses, on 7/28/14 at 2:35 p.m. The notes included, but were not limited to, the following: 6/27/14 "Received a call from Charge Nurse [LPN #5] stating [Resident #48] was upset over the Resident Council meeting, stating he was going to get [Resident #68] back. DNS [Director of Nursing Services] instructed charge nurse to keep the two separated and if any issues to call DNS back. Charge Nurse instructed [Resident #68] to come to DNS office on Monday." 6/30/14 "[Resident #68] did not come to DNS office. DNS interviewed [Resident #48] and he totally denied making any statements of harm about [Resident #68]. [Resident #48] to stay away from [Resident #68], he stated he definitely would stay away. 7/1/14 "DNS and ED [Executive Director/Administrator] met with [Resident #68] and she stated he was going to get back at her. [Resident #68] did say this was not told to her directly by [Resident #48], but by LPN #5 telling her to stay away from him as instructed by the DNS." A policy and procedure for Resident Compliment/Concern Policy (No date) was provided by the Administrator on			

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	7/28/14 at 3:07 p.m. The policy and procedure included, but was not limited to, the following: "To provide residents, their families, or representatives a means to express any compliments or concerns in a manner that may remain confidential if the resident so desires." "You may obtain a compliment/concern form at the nurses' station located on the 4th floor." "Please fill out the form with a description of the area you are wishing to communicate." "If you would like a return response, please sign the form as indicated." "You may place the form in the communication box located at the 4th floor nurses' station." "Within 5 working days, there will be some form of resolution if your communication is related to a concern." "If your communication is related to a concern and you are dissatisfied with the resolution, you may request a meeting with the Administrator to discuss your concerns further." "It is our staff's responsibility to assist you in any way necessary in obtaining the form or assisting you with completion at your request."			

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R000297	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on observation, record review, and interview, the facility failed to ensure pharmaceutical services were provided in 2 of 10 residents reviewed in that, 2 residents did not receive medications related to the pharmacy not delivering them. (Resident #A, Resident #93) Findings include: 1. The clinical record of Resident #A was reviewed on 7/23/14 at 2:30 p.m. Resident #A had a physician's order for Seroquel XL (a medication used for treating psychotic behaviors) 150 mg 1 (one) tablet po (orally) every bedtime. A MAR (Medication Administration Record), dated 7/1/14 through 7/31/14, indicated the Seroquel XL was not given from 7/11/14 through 7/15/14. A notation on the back of the MAR, dated 7/12/14 at 8:00 p.m., indicated the Seroquel XL was unavailable from the pharmacy. A physician's order, dated 7/13/14,	R000297	The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident A has moved out of state to be with her daughter and is no a resident. Upon review of the MAR of the resident identified as # 93 is now receiving all of their medications in accordance with the physician's orders.The corrective action taken for the other residents having the potential to be affected by the same practice is that a house wide audit of residents' medications has been conducted to ensure that all ordered medications are available for the residents. Any missing medications have been ordered and received in a timely manner. The measures that have been put into place to ensure that the deficient practice does not recur is that a meeting has been conducted between the facility administration and the providing pharmacy. An agreement has been made that if the providing pharmacy cannot deliver the medications to the facility in a	08/28/2014

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	indicated Resident #A was to receive Seroquel XL 150 mg tablet 1 po times 1 dose when delivered from the pharmacy. A notation, dated 7/13/14, indicated a Seroquel had been given to Resident #A at 2:27 a.m. No further documentation was located for 7/11/14, 7/13/14, or 7/15/14. 2. The clinical record for Resident #93 was reviewed on 7/23/14 at 11:00 a.m. Resident #93 had a physician's order, dated 5/9/14: Zestril (a medication used for blood pressure) 10 mg po (orally) every morning, K-dur (a potassium supplement) 20 mEq (millequivalent) 1 tablet po daily, and Atarax (an antihistamine) 50 mg tab 1 po qid (four times a day). A MAR (Medication Administration Record) indicated on 5/10/14 the medications were not available from pharmacy. Resident #93 had a physician's order, dated 6/9/14, for Debrox Otic (ear) drops (a medication used to soften ear wax) for 2 (two) drops in each ear bid (two times a day) for 30 days. The MAR (Medication Administration Record), dated 6/9/14 through 6/30/14, indicated Resident #93 did not receive the Debrox drops on		timely manner that the medications will be obtained from a local back-up pharmacy to ensure that the residents receive their medications as ordered. A mandatory in-service has been conducted for all licensed nurses and QMA on timely medication delivery procedures. The corrective action taken to monitor to assure compliance is that a Quality Assurance tool has been developed and implemented to ensure that each resident's medications are available for administration as ordered by their physician. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, and then monthly for three months and then quarterly for two quarters. The outcome of these tools will be reviewed at the facility's Quality Assurance Meeting to determine of any additional actions is warranted.	

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	6/10/14, 6/11/14, and 6/12/14. The back of the MAR indicated the Debrox drops were not available from pharmacy. Resident #93 had a physician's order, dated 5/30/14, for Lyrica 75 mg (milligram) 2 (two) capsules po (orally) bid (2 times a day). A MAR (Medication Administration Record), dated 5/30/14, indicated the Lyrica was not given at 8:00 p.m., as the dosage was unavailable. Resident #93 had a physician's order, dated 5/30/14: Guaifenesin (a medication used for chest congestion) 400 mg tablet 1 po tid (3 times a day), Multivitamin with minerals 1 tablet po daily, and Vitamin B12 1000 mcg tablet 1 po bid. A notation on the back of the MAR, dated 6/1/14 at 4:00 p.m., indicated "not all meds available." An untitled policy, dated 11/2012, indicated, "If the medication is out of stock, the pharmacy will be contacted to deliver the medication as soon as possible." During an interview on 7/24/14 at 3:30 p.m., LPN #1 indicated when medications are needed, pharmacy is notified. LPN #1 indicated the pharmacy			

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	is located in Indianapolis. LPN #1 further indicated if they need a medication sooner they will have the physician order the medication stat (immediately). This State Tag relates to Complaint #IN000152645.			