

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2015
--	---	---	---

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

(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) COMPLETION DATE
R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: June 22, 23, 24, 2015</p> <p>Facility: 011274 Provider number: 011274 AIM number: N/A</p> <p>Census bed type: Residential: 99 Total: 99</p> <p>Census payor type: Medicaid: 95 Other: 4 Total: 99</p> <p>Residential Sample: 7</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.</p>	R 0000	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 correction be considered our allegation of compliance effective July 25, 2015 to the state findings of the State Residential Licensure Survey conducted on June 22, 23, 24, 2015.	
R 0092 Bldg. 00	<p>410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows:</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2015
--	---	---	---

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

(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) COMPLETION DATE
	<p>(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.</p> <p>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>Based on interview and record review, the facility failed to conduct quarterly fire drills for 6 (six) of 12 (twelve) months reviewed of fire drills provided for all staff members and failed to conduct fire drills with the local fire department. This had the potential to affect all 99 residents in the facility.</p> <p>Findings include:</p> <p>1. During an interview on 6/22/15 at 1:30 p.m., Resident #1 indicated he had resided in the facility for 2 (two) years and the facility had not had a fire drill. Resident #2 indicated most of the residents in wheelchairs ate their meals in</p>	R 0092	The corrective action taken for those residents found to be affected by the deficient practice is that no specific residents were identified however all residents have the potential to be affected The facility has reviewed its policy and procedure on fire drills The Lead Houseman has be re-educated by the Administrator on the facility fire drill policy as well as instructions on his responsibility for conducting fire drills in accordance with facility policy and maintaining accurate records of each fire drill conducted The facility has also scheduled a fire drill to be conducted in conjunction with the local fire department The corrective action taken for the other residents having the	07/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/24/2015	
NAME OF PROVIDER OR SUPPLIER RIVERWALK COMMUNITIES LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 401 SE SIXTH ST EVANSVILLE, IN 47713			
(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) COMPLETION DATE			
	<p>the dining room and he was afraid something terrible might happen if the facility ever had a fire.</p> <p>2. During an interview on 6/22/15 at 3:05 p.m., Resident #2 indicated he had been a resident for the past 2 months. Resident #2 indicated the facility had not had a fire drill.</p> <p>3. During an interview on 6/23/15 at 8:45 a.m., Resident #8 she had been here for over a year and the facility had not had a fire drill.</p> <p>4. During review of the "Fire Drills" binder on 6/23/15 at 2:15 p.m., the binder indicated staff who had attended fire drills were not working or present during the drill. The following dates of attendance of absent staff were as follows from 12/18/15 through 5/15/15:</p> <p>CNA (Certified Nursing Assistant) #1 was listed on the sign-in sheet but was not present on 12/18/14 at 6:00 a.m., 2/12/15 at 6:00 a.m., 3/27/15 at 6:00 a.m., 4/10/15 at 6:00 a.m., and 5/15/15 at 6:00 a.m.</p> <p>CNA #2 was listed on the sign-in sheet but was not present on 3/27/15 at 3:00 p.m. and 5/15/15 at 4:00 p.m.</p> <p>DA #1 was listed on the sign-in sheet but was not present on 1/29/15 at 3:00 p.m.</p>		<p>potential to be affected by the same deficient practice is that all residents have the potential to be affected by the deficient practice. The facility has reviewed it's policy and procedure on fire drills The Lead Houseman has been re-educated by he Administrator on the facility fire drill policy as well as instructions on his responsibility for conducting fire drills in accordance with facility policy and maintaining accurate records of each fire drill conducted The facility has also scheduled a fire drill to be conducted in conjunction with the local fire department The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been conducted for all facility staff on the facility's fire safety program as well as on the policy related to fire drills with an emphasis on what each staff member's responsibility is during a fire drill or an actual fire The corrective action taken to monitor to ensure the deficient practice will not recur is that the facility has adopted the practice that all fire drill documentation will be reviewed at the facility Quality Assurance Committee meeting each quarter. Upon review of the documentation the QA Committee will take any additional action that may be warranted. This will be an</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2015
--	---	---	---

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

(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) COMPLETION DATE
	<p>4. During an interview on 6/22/15 at 2:25 p.m., LPN (Licensed Practical Nurse) #1 indicated he/she did not know or remember when the last fire drill was conducted,</p> <p>5. During an interview on 6/23/15 at 7:45 a.m., Housekeeper #1 indicated the facility had a fire drill last week. Housekeeper #1 indicated the facility has fire drill every week or every other week.</p> <p>6. During an interview on 6/23/15 at 10:20 a.m., QMA (Qualified Medication Aide) #2 indicated during a fire or fire drill the staff on the unit would shut all the resident room doors. Upon further query, QMA #2 indicated if a resident was visiting from another floor, the staff would place the resident in the lobby or a safe place. QMA #2 indicated she could not recall every step needed to do for the fire/drill.</p> <p>6. During an interview on 6/23/15 at 10:30 a.m., LPN #2 indicated the facility had not had a fire drill since last year.</p> <p>7. During an interview on 6/23/15 at 3:05 p.m., Housekeeper #2 indicated he was the person who conducted the fire drills for the facility. Housekeeper #2 indicated he did not want more staff then</p>		on-going process as part of the regular scheduled QA Meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2015
--	---	---	---

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

(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) COMPLETION DATE
	<p>necessary to "head to the fire." He indicated he preferred only 4 staff members, which included 2 maintenance persons, 1 dietary person, and 1 housekeeper, come to the location of the fire drill and the rest of the staff to remain on the floor with the residents. Housekeeper #2 indicated he would give the clipboard to another staff member to obtain the names of staff that came to the drill. Upon query regarding the names of staff being spelled incorrectly, on vacation, not working, and in the same handwriting in the binder, Housekeeper #2 indicated the issue would be addressed. Housekeeper #2 indicated he was unaware fire drills were to be conducted quarterly on each shift with all facility staff. Housekeeper #2 also indicated he was unaware the facility was to attempt to hold a fire drill in conjunction with the local fire department at least every 6 (six) months.</p> <p>A policy for fire drills, dated 1/10, and obtained from the Administrator on 6/23/15 at 5:00 p.m., indicated the facility would conduct monthly fire drills on all shifts. The policy further indicated all personnel in the facility should respond in exactly the same manner they would as if an actual fire was discovered,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2015
--	---	---	---

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

(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) COMPLETION DATE
R 0144 Bldg. 00	<p>410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the building was maintained in clean and or in good repair, in that, 5 of 7 resident rooms floors were dirty with dirt and debris, carpets were stained, tile was coming unglued outside of the nurse's station, a door vent had dirt on it, and the 6th floor had an odor. This had the potential to affect 99 (ninety-nine) residents of the facility. (Room 312, Room 410, Room 521, Room 528, Room 606, 4th floor nurse's station, Hall doors on the 5th floor and 6th floor, 6th floor)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During an observation on 6/22/15 at 3:15 p.m., Room 312 was observed. Room 312 had dirt and paper on the floor and the window was unclear. 2. During an observation on 6/22/15 at 3:30 p.m., Room 410 was observed. The 	R 0144	The corrective action taken for those residents found to be affected by 0144 is that room 312 has been thoroughly cleaned including the floor and windows Rooms 410, 512 and 606 has been thoroughly cleaned Room 528 has had the carpeting removed and vinyl flooring installed The hall door vent betweenrooms516 and 517 has been cleaned The hall door vent on 6th floor has been cleaned No specific residents were identified during the survey as having a urine odor on 6th floor This issue was not addressed with management during the survey or at exit conference Currently no urine odor can be detected on 6th floor The corrective action taken for the other residents having the potential to be affected by 0144 is that a house wide sanitation audit has been completed on each resident's room as well as the hallways and other common areas of the facility All areas in need of additional cleaning/repairs that were identified during this audit havwe	07/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/24/2015	
NAME OF PROVIDER OR SUPPLIER RIVERWALK COMMUNITIES LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 401 SE SIXTH ST EVANSVILLE, IN 47713			
(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) COMPLETION DATE			
	<p>floor had dirt on it. The same was observed on 6/23/15 at 9:10 a.m.</p> <p>3. During an observation on 6/22/15 at 11:15 a.m., Room 512 was observed. Room 512 had dirt on the floor. The same was observed on 6/22/15 at 2:55 p.m.</p> <p>4. During an observation on 6/22/15 at 9:20 a.m., Room 528 was observed. The carpet in the room had stains on it. The same was observed on 6/23/15 at 2:15 p.m.</p> <p>5. During an observation on 6/22/15 at 10:25 a.m., Room 606 was observed to have dirt on the floor. The same was observed on 6/22/15 at 1:55 p.m.</p> <p>6. During an observation on 6/22/15 at 10:55 a.m., the 4th (fourth) floor Nurse's Station had 2 (two) pieces of tile which were pulling up from the floor. The same was observed on 6/23/15 at 7:55 a.m.</p> <p>7. During an observation on 6/23/15 at 7:45 a.m., a hall door on the 5th (fifth) floor, between rooms 516 and 517, had a vent in the door. The vent had dust on it. The same was observed on 6/24/15 at 9:23 a.m.</p> <p>8. During an observation on 6/23/15 at</p>		<p>been cleaned/repared. The measures or systematic changes that have been put into place to ensure that the deficient practice does ont recur is that the facility has reviewed and revised the cleaning schedules. A mandatory in-service has been provided for all housekeeping staff on the facility's revised cleaning/repair practices. The daily cleaning schedules has been reviewed with the housekeepers to ensure their knowledge of the required cleaning practices. The housekeeping staff was also instructed on the facility's policy on reporting to maintenance any needed repairs that may be identified during their daily cleaning of the facility. The corrective actin taken to monitor to ensure the deficient practice does not recur is that a Quality Assurance tool has been developed and implemented to monitor the cleanliness of the facility and to ensure that the environment is in a good and safe condition This tool will be competed by the Administrator and/or her designee weekly for four weeks and then monthly for three months then quarterly for one quarter The outcome of this tool will be reviewed at the quarterly Quality Assurance meeting to determine if any additional action is warranted</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/24/2015	
NAME OF PROVIDER OR SUPPLIER RIVERWALK COMMUNITIES LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 401 SE SIXTH ST EVANSVILLE, IN 47713			
(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) COMPLETION DATE			
R 0153 Bldg. 00	<p>7:45 a.m., a hall door on the 6th (sixth) floor had a vent in it. The vent had dust on it. The same was observed on 6/24/15 at 9:25 a.m.</p> <p>9. During an observation on 6/23/15 at 7:50 a.m., the 6th floor had a strong urine odor. The same was observed on 6/23/14 at 9:10 a.m.</p> <p>10. During an interview on 6/24/15 at 7:30 a.m., Housekeeping #1 indicated the resident's rooms were dusted, swept and mopped daily. Housekeeping #1 indicated the resident rooms deep cleaned once a month on a rotating schedule.</p> <p>11. A housekeeping schedule, obtained from the Administrator on 6/23/15 at 4:30 p.m., indicated the resident rooms were to be swept and mopped daily. The schedule indicated each resident room was to be "deep" cleaned once a month.</p> <p>410 IAC 16.2-5-1.5(j) Sanitation and Safety Standards - Deficiency (j) The facility shall observe safety precautions when oxygen is stored or administered in the facility. Residents on oxygen shall be instructed in safety measures concerning storage and</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/24/2015	
NAME OF PROVIDER OR SUPPLIER RIVERWALK COMMUNITIES LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 401 SE SIXTH ST EVANSVILLE, IN 47713			
(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) COMPLETION DATE			
	<p>administration of oxygen.</p> <p>Based on interview, observation, and record review, the facility failed to store oxygen tanks in a safe and secure environment, in that, the ceiling had fallen in the oxygen storage room for 1 of 1 oxygen storage room on the sixth floor. This had the potential to affect all 31 residents on the sixth floor of the facility.</p> <p>Findings include:</p> <p>During an interview on 6/22/15 at 3:00 p.m., Resident #2 indicated the ceiling on the sixth floor was falling in. Resident #2 indicated whenever it rained several of the rooms would leak on the unit.</p> <p>During an observation on 6/23/15 at 10:15 a.m., the oxygen storage room was observed. The room had an exposed area on the ceiling around a vent in which the ceiling paint/paper had fallen to the floor and onto a countertop and sink area. The ceiling paint/paper was lying on the oxygen tanks, a nebulizer machine, and tubing. The exposed area around the vent also appeared to be wet.</p> <p>During an interview on 6/23/15 at 10:20 a.m., LPN (Licensed Practical Nurse) #3 indicated she did not know what had happened in the room but it was in a</p>	R 0153	<p>The corrective action taken for those residents found to be affected by 0153 is that the oxygen storage room on the sixth floor has been cleaned and the ceiling repaired around the vent. The area of the leak has been sealed and the oxygen storage room is now clean and in good condition. The corrective action taken for the other residents having the potential to be affected by 0153 is that a housewide audit of all rooms on the sixth floor was conducted to identify any other areas in need of repair due to a leaking roof. All ceilings on the sixth floor are now in good condition. The oxygen storage area on the fourth floor was also checked and is clean and in good condition. The measures or systematic changes that have been put into place to ensure that 0153 does not recur is that the facility policy on the process of reporting any areas/equipment in need of repair along with the policy on oxygen storage was reviewed. A mandatory in-service has been provided for all staff on the facility's policy on reporting any areas/equipment in need of repair promptly to the maintenance department. The oxygen storage areas have also been added to the housekeepers cleaning schedules and are to be cleaned weekly. The corrective action taken to monitor to ensure that</p>	07/25/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2015
--	---	---	---

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

(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) COMPLETION DATE
R 0241 Bldg. 00	<p>mess. LPN #3 indicated she would notify the maintenance department.</p> <p>During an interview on 6/23/15 at 6:30 p.m., the Administrator (Adm) indicated she was not aware the ceiling had partially fallen but she would be checking on it. The Adm indicated the roof would leak at times when there was a heavy rain. The Adm indicated the leaks were repaired immediately when this occurred.</p> <p>A policy on maintenance, dated 11/2012 and obtained from the ADON (Assistant Director of Nursing on 6/23/15 at 2:57 p.m., indicated if an employees would see or know of a malfunction, the maintenance department would be notified immediately to correct the problem.</p> <p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by</p>		0153 does not recur is that a Quality Assurance tool has been developed and implemented to ensure the cleanliness of the oxygen storage areas as well as to ensure that the ceiling tiles were in good condition and free of any evidence of leaks This tool will be completed by the Administrator and /or her designee weekly for four weeks, then monthly for three months and then quarterly for one quarter. The outcome of this tool will be reviewed at the facility's quarterly Quality Assurance meeting to determine of any additional action is warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2015
--	---	---	---

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

(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) COMPLETION DATE
	<p>licensed nursing personnel or qualified medication aides.</p> <p>Based on observation, record review, and interview, the facility failed to administer medications as ordered by the physician for 1 of 5 residents reviewed during a medication pass and the facility failed to provide medication to a resident prior to departing for dialysis for 1 of 7 residents reviewed for medications, in that, documentation indicated the resident had refused the medications while the resident was at dialysis three times a week. (Resident #1)</p> <p>Findings include:</p> <p>During an observation on 6/22/15 at 11:07 a.m., QMA (Qualified Medication Aide) #3 was observed to administer Renvela (a medication used to lower high blood phosphorus levels) 800 mg (milligrams) 2 (two) tablets orally to Resident #1.</p> <p>The clinical record of Resident #1 was reviewed on 6/22/15 at 12:10 p.m. Resident #1 had diagnoses including, but not limited to, end stage renal disease, hypertension, dyspnea, depression, GERD (gastroesophageal reflux disease), edema, and fluid in pleural cavity. Resident #1 had a physician's order, dated</p>	R 0241	<p>The corrective action taken for those residents found to be affected by 0241 is that the resident identified as resident # 1 is not receiving his medications in accordance with physician's orders. The resident's physician has been contacted regarding the resident's drug regimen and his dialysis schedule. A physician's order has been obtained to change the time of medication administration to coincide with the resident's dialysis schedule. In addition the resident's physician is notified when the resident refuses his scheduled medications and this notification is documented in the clinical record. The corrective action taken for the other resident having the potential to be affected by 0241 is that an audit of medication administration has been conducted to ensure that all residents are receiving their medications in accordance with physician's orders. Residents receiving dialysis will have their medication regimen reviewed with their physician to ensure that the medications are scheduled to be administered in accordance with their dialysis schedule to ensure that no doses are missed. The facility has also implemented a new practice related to unavailable drugs due to medication is not covered under the resident's insurance plan.</p>	07/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/24/2015	
NAME OF PROVIDER OR SUPPLIER RIVERWALK COMMUNITIES LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 401 SE SIXTH ST EVANSVILLE, IN 47713			
(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) COMPLETION DATE			
	<p>12/6/13, for dialysis 3 (three) times a week on Tuesday, Thursday, and Saturday. Resident #1 had a physician's order, dated 2/25/14, for Renvela 800 mg 1 tablet orally 3 (three) times daily with each meal.</p> <p>During an interview on 6/22/15 at 12:10 p.m., QMA #3 indicated Resident #1 should have only received Renvela 1 tablet instead of 2 tablets.</p> <p>A nurse's note, dated 6/23/15 at 12:00 p.m., indicated Resident #1's physician had been notified regarding the medication error.</p> <p>A policy for medication, dated 5/06 and received from the ADON (Assistant Director of Nursing) on 6/23/15 at 4:30 p.m., indicated all medication was to be administered as prescribed. The policy further indicated the physician would be notified if a resident consistently refused the medication and/or if the medication is out of stock and cannot be delivered within a timely manner.</p> <p>On 6/22/15 at 1:30 p.m. during an interview with Resident # 1, indicated he did not receive his regular scheduled medications while he was at dialysis. He indicated his medications were just skipped that day. He indicated he does</p>		<p>Once the facility has received notification that a medication is not available due to the residents drug plan refusal to cover that medication, nursing staff will contact the physician for additional instructions. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all licensed nurses on the facility policy related to medication administration in accordance with physician's orders and the policy on physician notification of the residents refusal of medication. The licenses nurses and QMAs were also instructed on the facility policy when any residents' medications are not readily available for administration. The corrective action taken to monitor to ensure the deficient practice will not recur is that a Quality Assurance tool has been developed and implemented to monitor medication administration to ensure that the residents are receiving their medications in accordance with physician's orders, this includes residents receiving dialysis. The tool will also monitor to ensure that is documentation to reflect that the physician is notified upon the resident's refusal of medications. This tool will be completed by the Director of Nursing and/or his designee weekly for four week,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/24/2015	
NAME OF PROVIDER OR SUPPLIER RIVERWALK COMMUNITIES LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 401 SE SIXTH ST EVANSVILLE, IN 47713			
(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) COMPLETION DATE			
	<p>not take meals with him to dialysis, Resident #1 indicated he eats when he gets back to the facility.</p> <p>On 6/22/15 during resident interview, medical record review doctor order, and staff interview indicated the resident leaves at 10:00 a.m. - 4:00 p.m. for dialysis on Tuesday, Thursday, and Saturday. The drugs Clonazepam, Calcium Acetate, and Renvella are all due 1 1/2 hours after leaving facility for dialysis.</p> <p>On 6/22/15 at 3:30 p.m. the medical record review of the MAR (Medication Administration Record) indicated the resident had the following medications due at 11:30 a.m.:</p> <ol style="list-style-type: none"> 1. Clonazepam (a seizure medication, anti -anxiety, use for bi-polar, or Tic disorder) 0.5 mg 1 tablet orally 2. Calcium Acetate 665 mg (a calcium supplement) orally 3. Renvella (controls phosphorous levels for persons with kidney disease on dialysis) 800 mg with each meal. <p>Review of the MAR sheet on 6/22/15 and 6/23/15 indicated the above medications were not given on dialysis days since February 2015. The MAR sheets on the following dates indicated:</p>		<p>then monthly for three months and then quarterly for one quarter. The outcome of this tool will be reviewed at the facility's quarterly Quality Assurance meeting to determine if any additional action is warranted</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2015
--	---	---	---

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

(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) COMPLETION DATE
	<p>6/23/15 at 12:00 p.m. indicated resident refused meds, could not locate- resident was at dialysis</p> <p>6/22/15 at 11:25 p.m. indicated resident Clonazepam with held due to physical condition</p> <p>6/21/15 at 8:15 p.m. indicated resident refused Requip x 3- resident allergic</p> <p>6/19/15 at 12:00 p.m. Clonazepam with held due to physical condition</p> <p>5/12/15 at 8:00 a.m. Clonazepam 0.5 mg - medication not available</p> <p>5/13/15 at 1200 p.m. Clonazepam 0.5 mg medication not available taken for EDK</p> <p>5/11/15 at 8:00 p.m. Clonazepam 0.5 mg not available - pharmacy notified.</p> <p>5/10/15 at 12:00 p.m. refused meds- could not find him a Sunday</p> <p>5/9//15 at 12:00 p.m. refused meds- LOA - Saturday- dialysis day</p> <p>4/15/15 at 11:30 a.m. resident was a no show for medications, paged.</p> <p>4/14/15 at 8:00 a.m. Sensipar (hyperparathyroidism) 60 mg- not available</p> <p>4/9/15 at 8:00 a.m. Sensipar 60 mg- not available</p> <p>4/8/15 at 8:00 a.m. Sensipar 60 mg - not available</p> <p>4/5/15 at 8:00 a.m. Sensipar 60 mg - not available</p> <p>4/4/15 at 8:00 a.m. Sensipar 60 mg - not available</p> <p>4/1/15 at 8:00 a.m. Sensipar 60 mg - not available</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/24/2015	
NAME OF PROVIDER OR SUPPLIER RIVERWALK COMMUNITIES LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 401 SE SIXTH ST EVANSVILLE, IN 47713			
(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) COMPLETION DATE			
	<p>3/17/15 at 12:00 p.m. Resident refused meds at dialysis</p> <p>3/14/15 at 13:00 p.m. Resident no show for meds - Saturday</p> <p>3/3/15 at 12:00 p.m. Resident no show for meds - Tuesday</p> <p>On 6/23/15 the Self Administration Assessment indicated Resident #1 wishes not to self administer medications, which is signed by resident on 8/22/13.</p> <p>ON 6/22/15 at 3:00 p.m. QMA #1 indicated if residents do not show up for their medications, he pages them overhead, then goes to their rooms.</p> <p>ON 6/23/15 at 9:20 a.m. indicated that when residents go out for dialysis it is their responsibility to come to the nurses station to receive their medications. The residents can get them early or sign them out to take with them to dialysis, if they fail to do so the residents just miss those medications for the day.</p> <p>On 6/23/15 a sign was noted on a wall near the nurses station to the resident's room which stated " To all Riverwalk Residents: We need your cooperation with Medication Administration, please check with your nurse on the times your medication is ordered. She will give this to you in writing to help you remember.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2015
--	---	---	---

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

(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) COMPLETION DATE
R 0242 Bldg. 00	<p>Be on time to receive your routine medication. We need your help, the nurses are busy and do not have time to track you down. It is your responsibility in Assisted Living to get your medications on time. "</p> <p>On 6/23/15 at 11:00 a.m. a copy of the resident's care requirement for initial and semi annual review on 2/25/15, indicated under Medications- the resident required complete supervision and administration of all medications.</p> <p>On 6/23/15, a policy was received from the DON at 11:00 a.m. indicated, but not limited too, all medication would be administered as prescribed. If a regularly scheduled medication was withheld or refused, the nurse/QMA could initial and circle the initial in the residents medication. The physician would be notified if the patient consistently refused medication and treatments.</p> <p>410 IAC 16.2-5-4(e)(2) Health Services - Offense (2) The resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/24/2015	
NAME OF PROVIDER OR SUPPLIER RIVERWALK COMMUNITIES LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 401 SE SIXTH ST EVANSVILLE, IN 47713			
(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) COMPLETION DATE			
	<p>Based on interview and record review, the facility failed to ensure 1 of 7 residents, whose allergies were reviewed, received a medication which caused an allergic reaction, in that, the allergy was not listed on the physician's order, the MAR (Medication Administration Record), or the clinical record. (Resident #1)</p> <p>Findings include:</p> <p>The clinical record of Resident #1 was reviewed on 6/22/15 at 12:10 p.m. Resident #1 had diagnoses including, but not limited to, end stage renal disease, hypertension, dyspnea, depression, GERD (gastroesophageal reflux disease), edema, and fluid in pleural cavity. The "Emergency Information" sheet indicated Resident #1 had allergies including, but not limited to, Hydralazine (an antihypertensive), Vancomycin (an antibiotic), Prednisone (a steroid), Toradol (anti-inflammatory) and Requip (a medication used for restless leg syndrome. The cumulative physician's orders for February, March, April, May and June, 2015, indicated Resident #1 only allergies were Hydralzine and Vancomycin.</p> <p>A physician's order, dated 2/25/15,</p>	R 0242	<p>The corrective action taken for those residents found to be affected by 0242 is that the resident identified as resident #1 is not longer receiving any medications that may be considered an allergy. The corrective action taken for the other residents having the potential to be affected by 0242 is that a housewide audit has been conducted to ensure that all of the residents known allergies are documented on the clinical record and that the resident is not receiving any medications that they have an known allergy to The measures or systematic changes that have been put into place to ensure that 0242 does not recur is that a mandatory in-service has been provided for all licensed nurses related to the importance of documenting all know allergies on the clinical record The nurses were also instructed on the importance of reviewing the resident's medication orders to ensure that the resident's current drug regimen is free of any medications that the resident has a known allergy to The corrective action taken to monitor to ensure the deficient practice will not recur is that a Quality Assurance tool has been developed and implemented to monitor the documentation to ensure that all know allergies are listed on the clinical record and that the resident's current drug regiment</p>	07/25/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/24/2015	
NAME OF PROVIDER OR SUPPLIER RIVERWALK COMMUNITIES LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 401 SE SIXTH ST EVANSVILLE, IN 47713			
(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) COMPLETION DATE			
	<p>indicated Resident #1 had an order for Requip 0.5 mg (milligrams) 1 (one) tablet orally at bedtime.</p> <p>A nurse's note, dated 6/19/15 at 1:00 p.m., indicated Resident #1 had complaints of weakness and dizziness. The nurse's note indicated Resident #1's physician was notified and an order was received for the resident to have a CBC (complete blood count) and a CMP (comprehensive metabolic panel) completed.</p> <p>A nurse's note, dated 6/20/15 at 7:00 p.m., indicated Resident #1 requested to go to the ER (Emergency Room). The note indicated Resident #1 continued to have complaints of weakness, dizziness, and his head leaning to the left side. The ER discovered that on his medical records he was allergic to Requip, which is listed on emergency information sheet, and had a daily order for Requip. The Resident # 1 was given Bendaryl (antihistamine) IV (intravenously) and sent back to the facility.</p> <p>On 6/21/15 at 8:00 p.m., a nurse's note indicated Resident #1 refused the Requip.</p> <p>On 6/22/15 at 1:30 p.m., during an interview with Resident #1, the resident indicated he had an ER visit on 6/20/15.</p>		<p>does not include any medications that the resident has a known allergy to This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months and quarterly for one quarter. The outcome of this tool will be reviewed at the facility's quarterly Quality Assurance meeting to determine if any additional action is warranted</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/24/2015	
NAME OF PROVIDER OR SUPPLIER RIVERWALK COMMUNITIES LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 401 SE SIXTH ST EVANSVILLE, IN 47713			
(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) COMPLETION DATE			
R 0297 Bldg. 00	<p>Resident #1 indicated while in the ER, he was informed by the physician, that he had been receiving a medication that he was previously allergic to. Resident #1 indicated the ER physician informed him the medication was Requip. The resident indicated he received an IV (intravenous) and an IV antihistamine medication.</p> <p>On 6/22/15, a physician's order indicated the Requip was to be discontinued and replaced with Miroplex (a medication for restless leg).</p> <p>On 6/24/15 at 9:20 a.m., an interview with the ADON (assistant director of nursing) and the DON (director of nursing) indicated the admission nurse was responsible for ensuring allergies are transcribed from the admission information to the chart and the physician's orders.</p> <p>On 6/24/15 at 10:00 a.m., the ADON indicated the facility lacked a policy for transcribing information on the MAR and the clinical record.</p> <p>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:</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2015
--	---	---	---

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

(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) COMPLETION DATE
	<p>(1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana.</p> <p>Based on record review and interview, the facility failed to ensure medications were available from the pharmacy for 2 of 7 residents reviewed, in that, medications were not available for the residents as ordered by the physician. (Resident #1, Resident #2)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #2 was reviewed on 6/22/15 at 10:55 a.m. Resident #2 had a diagnoses including, but not limited to, Unstageable Pressure Ulcer, Osteomyelitis of Ankle and Foot, Paraplegia, and Chronic Anemia. Resident #2 had an order, dated 4/16/15, for Zinc Sulfate (a mineral supplement) 220 mg (milligrams) 1 (one) capsule orally daily for wound healing.</p> <p>The MAR (Medication Administration Record), dated 5/1/15 through 5/31/15, indicated the medication was not available on 5/1/15, 5/9/15, 5/10/15, and 5/11/15.</p> <p>During an interview on 6/23/15 at 6:00 p.m., the Administrator indicated if a</p>	R 0297	<p>The corrective action taken for those residents found to be affected by 0297 is that the resident identified as resident #2 is now receiving all of their medications in accordance with the physician's orders including the Zinc Sulfate The corrective action taken for those residents found to be affected by 0297 is that resident # 1 is now receiving all of their medications in accordance with the physician's orders including Clonazepam and Sensipar The corrective action taken for the other residents having the potential to be affected by 0297 is that an audit has been completed and all residents are receiving all of their medications in accordance with the physician's orders The measures or systematic changes that have been put into place to ensure that 0297 does not recur is that a mandatory in-service has been provided for all licenses nurses and QMAs on the facility policies related to the process of ordering and reordering medications, including the use of back-up pharmacy when medications are not readily available The corrective action taken to monitor to ensure that deficient practice will not recur is that a Quality Assurance tool has been</p>	07/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2015
--	---	---	---

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

(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) COMPLETION DATE
	<p>medication is not available from the facility pharmacy, the facility was to obtain the medication from a local pharmacy.</p> <p>2. On 6/20/15 at 1:30 p.m. during interview with Resident #1, he indicated he sometimes did not get his medication because it did not come from the pharmacy.</p> <p>The clinical record of Resident #1 was reviewed on 6/22/15 at 12:10 p.m. Resident #1 had diagnoses including, but not limited to, end stage renal disease, hypertension, dyspnea, depression, GERD (gastroesophageal reflux disease), edema, and fluid in pleural cavity.</p> <p>Review of the MAR sheet on 6/22/15 and 6/23/15 indicated the above medications were not given due to being unavailable by Pharmacy. The MAR (Medicine Administration Record) indicated on the following dates indicated:</p> <p>5/12/15 at 8:00 a.m. Clonazepam 0.5 mg (a medication used for anxiety) - medication not available 5/13/15 at 1200 p.m. Clonazepam 0.5 mg medication not available taken for EDK 5/11/15 at 8:00 p.m. Clonazepam 0.5 mg not available - pharmacy notified. 4/14/15 at 8:00 a.m. Sensipar (a medication used for hyperparathyroidism)</p>		<p>developed and implemented to ensure that all residents are receiving their medications in accordance with the physician's orders and that the facility recording policy is being followed for any medication that is not readily available to the resident This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months and then quarterly for one quarter The outcome of this tool will be reviewed at the facility's quarterly Quality Assurance meeting to determine if any additional action is warranted</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2015
--	---	---	---

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

(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) COMPLETION DATE
	<p>60 mg- not available 4/9/15 at 8:00 a.m. Sensipar 60 mg- not available 4/8/15 at 8:00 a.m. Sensipar 60 mg - not available 4/5/15 at 8:00 a.m. Sensipar 60 mg - not available 4/4/15 at 8:00 a.m. Sensipar 60 mg - not available 4/1/15 at 8:00 a.m. Sensipar 60 mg - not available</p> <p>6/22/15 at 3:45 p.m. interview with the ADON indicated if medications are not available from pharmacy, the pharmacy is notified and medication is sent, if pharmacy is closed their back up is a local 24 hour pharmacy.</p> <p>6/23/15 at 10:45 p.m. with the DON indicated if medications are unavailable, they call the pharmacy and get the code to unlock the EDK (emergency drug kit) and the medication was retrieved, if it is still unavailable the call the local 24 hour pharmacy.</p> <p>A policy titled, "Medication Ordering and Receiving From Pharmacy," obtained from the DON (Director of Nursing) on 6/23/15 at 11:00 a.m., indicated medications were to be received from the dispensing pharmacy on a timely basis. The policy indicated when a medication</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2015
--	---	---	---

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

(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) COMPLETION DATE
R 0349 Bldg. 00	<p>is unavailable, the pharmacy would be contacted to deliver the medication as soon as possible. The policy further indicated the physician would be notified if the patient consistently refused medications or treatments, or if a medication was unavailable and could not be delivered within a timely manner.</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on interview and record review, the facility failed to maintain accurate and complete clinical records on 1 of 7 residents that were reviewed for allergies, in that, a resident's allergies were not completely listed throughout the clinical record and the Medication Administration Record. (Resident #1)</p> <p>Findings include:</p> <p>The clinical record of Resident #1 was reviewed on 6/22/15 at 12:10 p.m. Resident #1 had diagnoses including, but</p>	R 0349	The corrective action taken for those residents found to be affected by 0349 is that the resident identified as resident #1 had had their clinical record up-dated to include all current allergies The corrective action taken for the other resident having the potential to be affected by 0349 is that an audit has been completed on all clinical records and the allergy listing have been up-dated to include all current allergies for each resident The measures or systematic changes that have been put into place to ensure that 0349 does not recur	07/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/24/2015	
NAME OF PROVIDER OR SUPPLIER RIVERWALK COMMUNITIES LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 401 SE SIXTH ST EVANSVILLE, IN 47713			
(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) COMPLETION DATE			
	<p>not limited to, end stage renal disease, hypertension, dyspnea, depression, GERD (gastroesophageal reflux disease), edema, and fluid in pleural cavity.</p> <p>On 6/23/15 at 9:25 a.m. during review of the clinical record, an Emergency Information Sheet was found to list all allergies, which included Hydralazine (anti-hypertensive), Vancomycin (antibiotic), Requip (medication for restless leg), Prednisone (steroid), and Toradol (anti-inflammatory).</p> <p>The routine doctors orders for February, March, April, May and June only indicated Hydralazine and Vancomycin listed as allergies. The orders also included the drug Requip 0.5 mg 1 tablet to be given at bedtime.</p> <p>On 6/24/15 at 9:20 a.m. interview with the ADON (assistant director of nursing) and the DON (director of nursing) indicated the admission nurse is responsible for making sure all allergies are transcribed from the admission information to the chart and doctors orders.</p> <p>On 6/24/15 at 10:00 a.m. the ADON indicated there is no policy on the admission nurse and her duties as to transcribing completely all information,</p>		<p>is that a mandatory in-service has been provided for all licensed nurses regarding their responsibility to ensure that all of the resident's current allergies as documented on the clinical record including the medication Administration record The corrective action taken to monitor to ensure 0349 will not recur is that a Quality Assurance tool has been developed and implemented to monitor the listing of all current allergies for each resident is documented on the clinical record including the medication administration record This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months and then quarterly for one quarter The outcome of this tool will be reviewed at the facility's quarterly Quality Assurance meeting to determine if any additional action is warranted</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/24/2015	
NAME OF PROVIDER OR SUPPLIER RIVERWALK COMMUNITIES LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 401 SE SIXTH ST EVANSVILLE, IN 47713			
(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) COMPLETION DATE			
R 0414 Bldg. 00	<p>including allergies, to the chart.</p> <p>410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the infection control program was maintained to prevent potential infections for 2 of 5 residents observed receiving care, in that handwashing procedures were not completed as necessary. (Resident #9, Resident #10)</p> <p>Findings include:</p> <p>1. During an observation on 6/22/15 at 11:05 a.m., LPN (Licensed Practical Nurse) #1 was observed to be performing an accucheck on Resident #9. LPN #1 was observed to wash her hands for 7 (seven) seconds prior to obtaining the resident's supplies. LPN #1 was observed to apply gloves, perform the fingerstick. LPN #1 removed her gloves and wiped the glucometer with a sanitizing wipe. LPN #1 obtained Resident #9's insulin and administered the insulin to the resident. LPN #1</p>	R 0414	<p>The corrective action taken for those residents found to be affected by 0414 is that the LPN identified as #1 has received one on one education on the facility policy related to handwashing and proper sanitizing of glucometers The resident identified as resident #9 is now receiving her accuchecks and administration of insulin in accordance with the acceptable standards of infection control practices The corrective action taken for those residents found to be affected by 0414 is that the QMA identified as QMA # 1 is no longer an employee of the facility The resident identified as resident # 10 is now receiving all of their medications in accordance with acceptable standards of practice The corrective action taken for the other residents having the potential to be affected is that there have been no other breaches of infection control identified The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory</p>	07/25/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/24/2015	
NAME OF PROVIDER OR SUPPLIER RIVERWALK COMMUNITIES LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 401 SE SIXTH ST EVANSVILLE, IN 47713			
(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) COMPLETION DATE			
	<p>washed her hands for 7 seconds after administering the insulin.</p> <p>2. During an observation on 6/22/15 at 4:05 p.m., QMA (Qualified Medication Aide) #1 was observed to be administering a Fentanyl (a narcotic analgesic medication) patch to Resident #10. QMA#1 was observed to sanitize their hands and apply gloves. After opening the patch, QMA #1 was observed to drop the patch onto the floor. QMA #1 was observed to retrieve the patch and placed a corner of the patch onto the corner of the medication cart. QMA #1 proceeded to obtain Resident #10's oral medications a cup of water, and a piece of tape to cover the patch after he applied it to the resident's skin.</p> <p>During an interview on 6/23/15 at 8:55 a.m., LPN #4 indicated hands should be washed for 20 (twenty) seconds prior to and between resident contacts. LPN #4 indicated if a medication is dropped, the medication should be discard.</p> <p>A policy for handwashing, obtained from the ADON (Assistant Director of Nursing) on 6/23/15 at 4:30 p.m., indicated the hands and forearm areas should be scrubbed vigorously for at least 20 seconds. The policy further stated hands should be washed/sanitized before</p>		<p>in-service has been provided for all licensed nurses and QMAs on the facility's infection control practices related to handwashing, accuchecks, insulin and medication administration Each licensed nurse and QMA has successfully completed a return demonstration on handwashing techniques in accordance with facility policy The corrective action taken to monitor to ensure that deficient practice will not recur is that a Quality Assurance tool has been developed and implemented to monitor compliance with handwashing, accuchecks, insulin and medication administration in accordance with facility policy and acceptable standards of infection control practices This tool will be completed by the Director of Nursing and/or designee weekly for four weeks then monthly for three months and then quarterly for one quarter</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/24/2015
NAME OF PROVIDER OR SUPPLIER RIVERWALK COMMUNITIES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 401 SE SIXTH ST EVANSVILLE, IN 47713		
(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) COMPLETION DATE	
	and after doing accuchecks.				