STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/09/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00369765, IN00377199, IN00371551, and IN00381248. Complaint IN00369765 - Unsubstantiated due to lack of evidence. Complaint IN00377199 - Unsubstantiated due to lack of evidence. Complaint IN00371551 - Substantiated. State deficiencies related to the allegations are cited at R0052. Complaint IN00381248 - Substantiated. State deficiencies related to the allegations are cited at R0052 and R0217. Survey dates: June 7, 8, 9, 2022 Facility number: 011274	R 0000	June 27, 2022 Brenda Buroker Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204-3003 RE: Riverwalk Communities Complaint Survey (IN00369765 IN00371551 IN00377199 IN00381248)	

	Residential Census: 92 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 10, 2022.		Event ID IJ5Z11 Dear Ms Buroker; The Indiana State Department of Health visited our facility on June 9, 2022 to conduct a Complaint Survey. By submitting the enclosed materials, we are not admitting to 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. We respectfully request our plan of correction be considered our allegation of compliance effective July 8, 2022, and respectfully request a desk review. If you have any questions please feel free to contact me at the facility. Respectfully submitted, Brandi Huffman	

			Riverwalk Communities Health Facility Administrator	
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to ensure a resident who required medications was not located or given his prescribed medications, resulting in hospitalization (Resident D); and failed to provide nursing care to a resident with low blood sugar who had fallen (Resident R), for 2 of 4 residents sampled for neglect. Findings include: 1. The closed clinical record of Resident D was reviewed on 6/8/22 at 1:25 P.M. Diagnoses included, but were not limited to,	R 0052	R 052 *1.) The corrective action taken for* *those residents found to have been affected by the deficient practice is that* the resident identified as resident D no longer resides at the facility. *2.) The corrective action taken for* *those residents found to have been affected by the deficient practice is that* the resident identified as resident R no longer resides at the facility. *The corrective action taken for the* *other residents that have the potential to be affected by the same deficient* *practice is that* all residents have the potential to be affected by this deficient practice. In the resident's admission agreement, it clearly states that it is the resident's responsibility to report to their nurses' station	07/08/2022

	CVA (stroke), diabetes, and memory deficit. A Resident Evaluation, dated 10/20/21, indicated: "Mobility: Independent, Uses cane...Mental Status: Mild impairment, some confusion, needs initial guidance, difficulty in remembering details...Behavior: No problems...Medications: Requires complete supervision and administration of all meds...." Documentation indicated the resident a history of falls, and had fallen on 10/21/21 and 10/25/21. The resident returned to the facility from the hospital on 11/13/21 with new orders for an antibiotic for a urinary tract infection. Nurses notes included the following notations: 11/16/21 at 2:00 P.M.: "Called to resident's room on 4th floor to eval [evaluate] resident. She [friend] stated he was acting funny...answers questions appropriately. Grasps equal et [and] strong. 'I'm okay! I just flopped down on my walker,' he stated. V/S [vital signs] WNL [within normal limits], speech appropriate. This nurse left room." 11/17/21 at 7:00 A.M.: "Asked		during routine medication administration times to receive their scheduled medications. The nurses and QMAs however, will check on any resident who does not report to the nurses' station during med pass times, to remind them that it is time for their medications in an effort to ensure that each resident receives their medications in accordance with their physician's orders. The nurses and QMAs are also providing the appropriate nursing care and services as needed by each resident including any additional first aide/care that may be needed at the time of a fall or at the time of any change in a resident's condition.	

	CNA's [sic] to make sure resident was up et ready for appt. [appointment]. Not in room." 11/17/21 at 7:30 A.M.: "Transport called stating they had waited, we paged resident to tell him Transportation was here. This nurse checked room. No one present." 11/17/21 at 1:00 P.M.: "Informed CNA's [sic] to make sure resident was ready for transportation at 1430 [2:30 P.M.]. CNA's stated he was not in room. Staff began looking for resident. Paging [with] no response. All staff asked to check resident rooms, empty rooms, shower rooms et bathrooms." 11/17/21 at 1:15 P.M.: "[Name of hospital] ER called to see if resident had been admitted...All ER in [city] called. No admission noted." 11/17/21 at 1:30 P.M.: [Family members] notified that father could not be located. Advised this nurse would keep them informed...staff continues to search." 11/17/21 at 3:00 P.M.: "Notified by CNA that resident found on 3rd floor in BR [bathroom] shower room. Floor covered in BM. Resident alert et smiling...." 11/17/21 at 5:00 P.M.:		*The measures 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 and QMAs on the facility's policy and procedures related to medication administration, fall protocols, including fall follow up assessments and the documentation required with any incident or change in condition. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implements to monitor medication administration and assessment documentation related to falls or any changes in the resident's condition. This tool will monitor medication administration to ensure that the resident is receiving their medications as ordered and that if the resident does not report to the nurses' station for med pass, that the staff checks on the resident to remind them that it is time for their medication. The tool will also monitor to ensure that the resident is	

	"Resident resting in bed. QMA assisting [with] supper meal et drink. Buttocks red, lotion applied...." A Medication Administration Record (MAR), dated November 2021, indicated Resident D received his 8:00 P.M. medications on 11/16/21. The MAR indicated the resident did not receive his 8:00 A.M. or 12:00 P.M. antibiotic, Cephalexin, on 11/17/21. The medication was circled as not given, with a notation ".Aspirin and Keflex [antibiotic][omitted]..resident not available." The MAR indicated the resident did not receive any of his 10:00 A.M. medications, which included: Aspirin, Junuvia (for diabetes), Flomax (for bladder), Myrbetriq (for bladder), Prilosec (for stomach acid), Zoloft (an anti-depressant), Glucophage (for diabetes), Metoprolol (for blood pressure), and Lisinopril (for blood pressure). A notation indicated, "Morning meds [omitted]...resident not available." A transfer form, dated 11/18/21 and untimed, indicated, "...few days ago started ATB [antibiotic] for UTI. Resident fell 11/17/21. Resident found in locked BR [bathroom] on floor covered in BM. Noted while transfer taken		properly assessed, including vital signs and blood sugars taken when warranted, when there is a fall or a change in the resident’s condition. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility’s Quality Assurance meetings to determine if any additional action is warranted.	

	like 4-6 people to help get up. Unable to ambulate. Very weak, unsteady...Resident very weak...Alert [with] some forgetfulness, confusion...." A hospital ER record, dated 11/18/21 at 2:35 P.M., indicated, "HISTORY OF PRESENT ILLNESS ...male with a past medical history notable for stroke with residual left-sided weakness...DM [diabetes mellitus] Type 2, chronic pain, GERD [gastroesophageal reflux disease], anxiety and depression, who presents with weakness. The patient was found on the toilet yesterday and had been sitting on there at least 15 hours. He has pain in his bottom as well as some muscle aches. He also feels weak and tired. He lives in assisted living after having a stroke...Mentation:Awake and alert. Oriented to person, place, and time...ASSESSMENT AND PLAN: Acute Rhabdomyolysis [muscle tissue breakdown]...Continuous IVF [intravenous fluids]...Generalized Weakness...Acute Transaminitis [high levels of enzymes]: likely secondary to rhabdomyolysis...." On 6/9/22 at 10:30 A.M., the Administrator was interviewed. She indicated Resident D had a			

history of sitting in the bathroom for hours. She indicated the resident had a girlfriend in the facility, and the resident had spent the night with the girlfriend. The Administrator was unable to say when the resident was definitely last seen by staff. After reading the nurses notes, the Administrator indicated the resident was found in the 3rd floor shower room bathroom. The resident did not have a call pendant. Residents were not provided call pendants, unless they wanted to privately pay for them.

2. The closed clinical record of Resident R was reviewed on 6/7/22 at 1:45 P.M. Diagnoses included end stage renal disease, legally blind, and type 1 diabetes mellitus.

A Resident Evaluation, dated 4/20/22, indicated, "Mobility: Requires supervision or escort assistance. Mental Status: Oriented, Behavior: Minimal supervision...."

Nurses notes, signed by QMA 2, indicated the following notations:

5/12/22 at 6:00 P.M.: "Resident on 4th floor talking to staff and other residents. Stated, 'Well I'm going to do my laundry....'"

6:20 P.M.: "Resident from 6th floor called and stated 'There is a resident laying on the floor

	outside the elevators on 3.' Upon going to 3rd floor noticed resident was sweating profusely and not responding. Called 911 upon this time. Then called his mother...EMTS started I.V. to [increase] sugar. Resident then coded. EMTs [and] fire department initiated CPR...1900 [7:00 P.M.] Resident stabilized and transported to [name of hospital]...." On 6/9/22 at 10:30 A.M., the Administrator was interviewed. She indicated she reviewed video footage from 5/12/22. She did not currently have the video footage. Resident R fell on the 3rd floor, got up, then fell again and did not get up. A resident coming off of the elevator saw him, and called QMA 2 on another floor. There was no nurse working. QMA 2 came down, and was not observed to take vital signs, or otherwise check Resident R. She called 911, and another QMA came down with the resident's chart. QMA 2 "was just standing there, and not doing anything." QMA 2 was terminated due to not following the facility's fall protocol of not taking vital signs or filling out a fall incident report. On 6/9/22 at 12:20 P.M., the Administrator provided the current facility policy, "Fall Follow Through Policy," dated 10/25/19. The policy included: "The nurse on the unit is			

responsible for completing an incident/accident form whenever a resident has a fall or is found on the floor. The nurse is also responsible for assessing the resident at the time for potential injuries as well as obtaining their vital signs including neuro checks if applicable...."

This State Residential Finding relates to Complaints IN00371551 and IN00381248.

Based on interview and record review, the facility failed to ensure a resident who required medications was not located or given his prescribed medications, resulting in hospitalization (Resident D); and failed to provide nursing care to a resident with low blood sugar who had fallen (Resident R), for 2 of 4 residents sampled for neglect.

Findings include:

1. The closed clinical record of Resident D was reviewed on 6/8/22 at 1:25 P.M. Diagnoses included, but were not limited to, CVA (stroke), diabetes, and memory deficit.

A Resident Evaluation, dated 10/20/21, indicated: "Mobility: Independent, Uses cane...Mental Status: Mild impairment, some confusion, needs initial guidance, difficulty in remembering details...Behavior: No

	problems...Medications: Requires complete supervision and administration of all meds...." Documentation indicated the resident a history of falls, and had fallen on 10/21/21 and 10/25/21. The resident returned to the facility from the hospital on 11/13/21 with new orders for an antibiotic for a urinary tract infection. Nurses notes included the following notations: 11/16/21 at 2:00 P.M.: "Called to resident's room on 4th floor to eval [evaluate] resident. She [friend] stated he was acting funny...answers questions appropriately. Grasps equal et [and] strong. 'I'm okay! I just flopped down on my walker,' he stated. V/S [vital signs] WNL [within normal limits], speech appropriate. This nurse left room." 11/17/21 at 7:00 A.M.: "Asked CNA's [sic] to make sure resident was up et ready for appt. [appointment]. Not in room."			

	11/17/21 at 7:30 A.M.: "Transport called stating they had waited, we paged resident to tell him Transportation was here. This nurse checked room. No one present." 11/17/21 at 1:00 P.M.: "Informed CNA's [sic] to make sure resident was ready for transportation at 1430 [2:30 P.M.]. CNA's stated he was not in room. Staff began looking for resident. Paging [with] no response. All staff asked to check resident rooms, empty rooms, shower rooms et bathrooms." 11/17/21 at 1:15 P.M.: "[Name of hospital] ER called to see if resident had been admitted...All ER in [city] called. No admission noted." 11/17/21 at 1:30 P.M.: [Family members] notified that father could not be located. Advised this nurse would keep them informed...staff continues to search." 11/17/21 at 3:00 P.M.: "Notified by CNA that resident found on 3rd floor in BR [bathroom] shower room. Floor covered in BM. Resident alert et smiling...." 11/17/21 at 5:00 P.M.: "Resident resting in bed. QMA assisting [with] supper meal et drink. Buttocks red, lotion applied...."			

	A Medication Administration Record (MAR), dated November 2021, indicated Resident D received his 8:00 P.M. medications on 11/16/21. The MAR indicated the resident did not receive his 8:00 A.M. or 12:00 P.M. antibiotic, Cephalexin, on 11/17/21. The medication was circled as not given, with a notation ".Aspirin and Keflex [antibiotic][omitted]..resident not available." The MAR indicated the resident did not receive any of his 10:00 A.M. medications, which included: Aspirin, Junuvia (for diabetes), Flomax (for bladder), Myrbetriq (for bladder), Prilosec (for stomach acid), Zoloft (an anti-depressant), Glucophage (for diabetes), Metoprolol (for blood pressure), and Lisinopril (for blood pressure). A notation indicated, "Morning meds [omitted]...resident not available."			

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	[high levels of enzymes]: likely secondary to rhabdomyolysis...." On 6/9/22 at 10:30 A.M., the Administrator was interviewed. She indicated Resident D had a history of sitting in the bathroom for hours. She indicated the resident had a girlfriend in the facility, and the resident had spent the night with the girlfriend. The Administrator was unable to say when the resident was definitely last seen by staff. After reading the nurses notes, the Administrator indicated the resident was found in the 3rd floor shower room bathroom. The resident did not have a call pendant. Residents were not provided call pendants, unless they wanted to privately pay for them. 2. The closed clinical record of Resident R was reviewed on 6/7/22 at 1:45 P.M. Diagnoses included end stage renal disease, legally blind, and type 1 diabetes mellitus. A Resident Evaluation, dated 4/20/22, indicated, "Mobility: Requires supervision or escort assistance. Mental Status: Oriented, Behavior: Minimal supervision...." Nurses notes, signed by QMA 2, indicated the following notations: 5/12/22 at 6:00 P.M.: "Resident			

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	On 6/9/22 at 10:30 A.M., the Administrator was interviewed. She indicated she reviewed video footage from 5/12/22. She did not currently have the video footage. Resident R fell on the 3rd floor, got up, then fell again and did not get up. A resident coming off of the elevator saw him, and called QMA 2 on another floor. There was no nurse working. QMA 2 came down, and was not observed to take vital signs, or otherwise check Resident R. She called 911, and another QMA came down with the resident's chart. QMA 2 "was just standing there, and not doing anything." QMA 2 was terminated due to not following the facility's fall protocol of not taking vital signs or filling out a fall incident report. On 6/9/22 at 12:20 P.M., the Administrator provided the current facility policy, "Fall Follow Through Policy," dated 10/25/19. The policy included: "The nurse on the unit is responsible for completing an incident/accident form whenever a resident has a fall or is found on the floor. The nurse is also responsible for assessing the resident at the time for potential injuries as well as obtaining their vital signs including neuro checks if applicable...."			

	This State Residential Finding relates to Complaints IN00371551 and IN00381248.			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (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 of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations	R 0217	R 217 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident D no longer resides at the facility. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. All residents are now receiving their medications under the direct supervision of the nurse and/or QMA unless they specifically have a physician's order that they may self-administer their medications. No medications are left unattended in the resident's room. *The measures that have been put into place to ensure that the*	07/08/2022

	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 observation, interview, and record review, the facility failed to ensure medications were not left in a resident's room unattended. The resident did not have a physician's order to self-administer medications. This affected 1 of 5 residents sampled during a medication pass (Resident D). Finding includes: On 6/7/22 at 10:00 A.M., QMA 1 was observed during a medication pass. QMA 1 indicated Resident D had dialysis that morning, and she needed to give him his medications. QMA 1 prepared the following medications for Resident D: Pepcid 20 mg (for stomach acid), Amlopidine 5 mg (for high blood pressure), Folic Acid 1 mg (a vitamin), Metoprolol ER 25 mg (for high blood pressure), Nuedexta 20/10 (to treat mood disorders), Calcium Acetate (a vitamin), Renvela 800 mg (used for		*deficient practice does not recur is that* a mandatory in-service has been provided for all nurses and QMAs on the facility's policy and procedure related to medication administration. The nurses and QMAs were specifically instructed that no medications are to be left unattended in the resident's room. Only residents who successfully complete a self-administration of medication assessment and have a current physician's orders may keep their medications in their room and self-administer as directed by their physician. *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 administration of medications in accordance with facility policy. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and the quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

residents who require dialysis), Buspar 15 mg (for anxiety), Clonazepam 1 mg (for anxiety), and Lokelma 10 grams (used for high potassium). QMA 1 took the medication cups into the resident's room, and took the resident's blood pressure. She indicated she would have to hold the resident's Metoprolol if this blood pressure was low, but that the blood pressure was a little high. She then left the resident's medications on a table across the room, and informed the resident the medications were on the table. QMA 1 then left the room.

On 6/7/22 at 11:15 A.M., QMA 1 indicated the resident was not supposed to receive the Metoprolol medication on the days that he goes to dialysis, and so she went and retrieved the Metoprolol. She indicated the medication was still in the medication cup.

The clinical record of Resident D was reviewed on 6/9/22 at 9:30 A.M.

A Physician's order, dated 4/21/22 and on the current June 2022 orders, indicated, "Metoprolol ER 25 mg...1 tablet by mouth daily. Hold AM dose day of dialysis. Give after dialysis."

A Resident Evaluation, dated 2/16/22, indicated: "Mental

Status: Moderate Impairment. Memory loss esp. of current events and gets agitated about memory loss. Strong reminders required...Medication: Resident requires complete supervision and administration of all medications."

A Physician's order which indicated the resident could self-administer his medications was not found in the clinical record.

On 6/9/22 at 12:20 P.M., the Administrator provided the current facility policy, "Self-Administration of Medication Assessment," dated 4/2019. The policy included: "Upon admission or at any time thereafter that the resident expresses the desire to self-administer their own medications, the nurse will complete a self-administration of medication assessment. Only residents deemed safe to self-administer medications by the interdisciplinary team will be permitted to self-administer medications...."

This State Residential Finding relates to Complaint IN00381248.

Based on observation, interview, and record review, the facility failed to ensure medications were not left in a resident's room unattended. The

resident did not have a physician's order to self-administer medications. This affected 1 of 5 residents sampled during a medication pass (Resident D).

Finding includes:

On 6/7/22 at 10:00 A.M., QMA 1 was observed during a medication pass.

QMA 1 indicated Resident D had dialysis that morning, and she needed to give him his medications. QMA 1 prepared the following medications for Resident D: Pepcid 20 mg (for stomach acid), Amlopidine 5 mg (for high blood pressure), Folic Acid 1 mg (a vitamin), Metoprolol ER 25 mg (for high blood pressure), Nuedexta 20/10 (to treat mood disorders), Calcium Acetate (a vitamin), Renvela 800 mg (used for residents who require dialysis), Buspar 15 mg (for anxiety), Clonazepam 1 mg (for anxiety), and Lokelma 10 grams (used for high potassium). QMA 1 took the medication cups into the resident's room, and took the resident's blood pressure. She indicated she would have to hold the resident's Metoprolol if this blood pressure was low, but that the blood pressure was a little high. She then left the resident's medications on a table across the room, and informed the resident the

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	current facility policy, "Self-Administration of Medication Assessment," dated 4/2019. The policy included: "Upon admission or at any time thereafter that the resident expresses the desire to self-administer their own medications, the nurse will complete a self-administration of medication assessment. Only residents deemed safe to self-administer medications by the interdisciplinary team will be permitted to self-administer medications...." This State Residential Finding relates to Complaint IN00381248.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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