STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	12/30/2024

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 a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00431867. Complaint IN00431867 - No deficiencies related to the allegations are cited. Survey dates: December 26, 27, and 30, 2024 Facility number: 011274 Residential Census: 78 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 8, 2025.	R 0000		
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training	R 0117	R117 By submitting the enclosed materials, we are not admitting	02/15/2025

	in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure there was personnel in the facility, all hours of operation, with first aid and CPR certification for 3 of 7 days reviewed. Findings included: On 12/27/2024 at 2:00 P.M., the facilities employee records, licensure, and working schedule		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 2/15/2025. The facility requests that this Plan of Correction and items submitted be considered for desk review and paper compliance. Observation Lack of Personnel with CPR First Aid Training On 12/27/2024 at 2:00 P.M., the facilities employee records, licensure, and working schedules were reviewed. On the dates of 12/21/2024, 12/22/2024, and 12/24/2024 the third shift (7 P.M. to 7 A.M.) lacked personnel with Cardiopulmonary Resuscitation (CPR) and first aid training both:	

	were reviewed. On the dates of 12/21/2024, 12/22/2024, and 12/24/2024 the third shift (7 P.M. to 7 A.M.) lacked personnel with Cardiopulmonary Resuscitation (CPR) and first aid training both. On 12/30/2024 at 10:00 A.M. the Administrator indicated that CPR and first aid certifications were something they are planning on working to improve. Indicated it was their practice to follow state regulations. Based on record review and interview, the facility failed to ensure there was personnel in the facility, all hours of operation, with first aid and CPR certification for 3 of 7 days reviewed. Findings included: On 12/27/2024 at 2:00 P.M., the facilities employee records, licensure, and working schedule were reviewed. On the dates of 12/21/2024, 12/22/2024, and 12/24/2024 the third shift (7 P.M. to 7 A.M.) lacked personnel with Cardiopulmonary Resuscitation (CPR) and first aid training both.		The corrective action taken immediately: The facility does ensure that all RWC licensed and certified nursing staff receive CPR and First Aid training. An audit of all RWC licensed and certified nursing staff was completed per HR, DON, or designee to determine which staff members needed certification/recertification. Action taken to prevent same deficiency: HR, DON, and designee then contacted licensed and certified nursing staff to complete training. All have received and completed CPR and First Aid training as of 1/20/2025.	

	On 12/30/2024 at 10:00 A.M. the Administrator indicated that CPR and first aid certifications were something they are planning on working to improve. Indicated it was their practice to follow state regulations.		The corrective action put in place to ensure deficient practice does not recur in the future is that audits will be completed monthly by HR, DON, or designee for all licensed or certified RWC personnel and verified upon hire to ensure continuing compliance. Audit results will be reviewed and monitored monthly in QA meeting.	
R 0123	Personnel - Nonconformance 410 IAC 16.2-5-1.4(h)(1-10) (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents'	R 0123	R123 By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 2/15/2025. The facility requests that this Plan of Correction and items submitted be considered for desk review and paper compliance.	02/15/2025

	rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on interview and record review, the facility failed to maintain current and accurate personnel records for all employees. The facility failed to have an updated certification for 1 of 12 Certified Nurse Aide (CNA)s reviewed. (CNA 15) Finding included: On 12/27/24 at 8:23 A.M., review of employee records indicated there was not a current certification for CNA 15. During an interview on 12/30/24 at 10:19 A.M., the DON (Director of Nursing) indicated the certification for CNA 15 had expired. At that time, review of Indiana Professional Licensing Agency online indicated CNA 15's certification expired on 4/18/24.		Observation CNA 15 did not hold a current CNA Certification: On 12/27/24 at 8:23 A.M., review of employee records indicated there was not a current certification for CNA 15. The corrective action taken immediately: The facility does ensure that all RWC licensed and certified nursing staff hold and maintain current license and certifications. An audit of all RWC licensed and certified nursing staff was completed per HR, DON, or designee to ensure all staff had current licenses and certifications. CNA 15 was immediately removed from RWC schedule 12/27/24. Action taken to prevent same deficiency: HR, DON, and designee have determined that all current licensed and certified RWC nursing staff hold current	

	During an interview on 12/30/24 at 11:38 A.M., the DON indicated the business office and scheduler monitor the license book. He indicated all licenses and certifications should be up to date. On 12/30/24 at 2:10 P.M., a License Renewal policy, dated 3/6/13, was provided by the DON which indicated "It is the responsibility of licensed personnel to renew job specific licensure when due...Personnel that fail to present facility with license will be unable to work until a current license is in employment file." Based on interview and record review, the facility failed to maintain current and accurate personnel records for all employees. The facility failed to have an updated certification for 1 of 12 Certified Nurse Aide (CNA)s reviewed. (CNA 15) Finding included: On 12/27/24 at 8:23 A.M., review of employee records indicated there was not a current certification for CNA 15. During an interview on 12/30/24 at 10:19 A.M., the DON (Director of Nursing) indicated the certification for CNA 15 had expired. At that time, review of Indiana Professional Licensing Agency online indicated CNA 15's certification expired on		licenses and certifications. The corrective action put in place to ensure deficient practice does not recur in the future is that audits will be completed monthly by HR, DON, or designee for all licensed or certified RWC personnel and verified upon hire for all newly hired licensed or certified RWC personnel upon hire to ensure continuing compliance. Audit results will be reviewed and monitored monthly in QA meeting.	

	4/18/24. During an interview on 12/30/24 at 11:38 A.M., the DON indicated the business office and scheduler monitor the license book. He indicated all licenses and certifications should be up to date. On 12/30/24 at 2:10 P.M., a License Renewal policy, dated 3/6/13, was provided by the DON which indicated "It is the responsibility of licensed personnel to renew job specific licensure when due...Personnel that fail to present facility with license will be unable to work until a current license is in employment file."			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, record review, and interview, the facility failed to ensure food was stored and served appropriately for 1 of 2 kitchen observations. Food was not labeled in reach in freezer, spices not labeled in the spice rack, resident refrigerator had unlabeled food, and food	R 0273	R273 By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 2/15/2025. The facility requests that this Plan of Correction and items	02/15/2025

	servers did not wash hands for the appropriate length of time. (kitchen, dining room) Findings included: On 12/26/24 at 9:20 A.M., during a tour of the kitchen the following was observed in the reach in freezer: 1 bottle of Sweet Baby Rays no open date with food build up on the neck of bottle 3 bottles of brown liquid containers no open date 2 cans of whipped cream with no open date At 9:40 A.M., in the blue spice rack next to the silver preparation table the following was observed: 1 container of beef paste no open date 1 container of Chile Powder no open date 1 container of Lowery Season Salt no open date 1 container of Corn Starch no open date 1 container of Bayside Seasoning no open date 1 container of Salt free Cajun Seasoning no open date		submitted be considered for desk review and paper compliance. Observation reach-in freezer: 1 bottle of Sweet Baby Rays no open date with food build up on the neck of the bottle 3 bottles of brown liquid containers no open date 2 cans of whipped cream with no open date The corrective action taken immediately was Sweet Baby Ray's food build up was wiped off bottle and items dated three days out were discarded. Action to prevent other items from falling under same deficiency was that Audit Tool was created to inspect all items in reach in freezer. Ensured all items were labeled and marked to include open dates. Any unlabeled items or items with no open dates were discarded. The corrective action put in place to ensure	

	1 container of Bay Leaves no open date 1 container of Lemon Pepper no open date 1 container of Rubbing Sage no open date 1 container of Thyme Leaves no open date 1 container of Whole Rosemary no open date 1 container of Garlic Powder no open date 2 containers of Salt Free Pepper no open date 1 container of Cinnamon no open date 1 container of Ground Pepper no open date 1 container of Fajita Seasoning no open date 1 container of Paprika no open date 1 bottle of Vanilla Extract no open date At 9:45 A.M., the following was observed in the Resident Refrigerator in the Dining Room: 1 can of cola with no name 1 container of red colored fluid with no name or open date		deficient practice does not recur in the future is that dietary staff will be in-serviced on Food Safety and Sanitation Policy. Quality Assurance Tool was put in place for Dietary Manager or designee to inspect each shift for 7 days, then daily for 7 days, then 3 times weekly for 7 days, then 2 times weekly for 7 days, then weekly for 7 days, then monthly to ensure all items are labeled and marked to indicate open dates. The Dietary Manager will keep a binder of daily/weekly checks. Observation blue spice rack: 1 container of beef paste no open date 1 container of Chile Powder no open date 1 container of Lowery Season Salt no open date 1 container of Corn Starch no open date 1 container of Bayside Seasoning no open date	

	1 Styrofoam container with [resident name] with date 12/23 5 containers of orange-colored liquids no name or dated Inside of refrigerator had spots of brown liquid splattered about the inside of top freezer On 12/27/24 at 11:45 A.M., during a random observation of lunch the following was observed: Dietary cook washed hands for 5 seconds in sink with soap and water before taking the food temperature. Dietary cook touched the inside rim of the plate when plating 2 meals for residents Kitchen Volunteer touched the inside rim while serving a resident their meal. During an interview on 12/26/24 at 9:25 A.M., the Dietary Manager indicated the creamers were here and should have had her name and open date on the creamers.		1 container of Salt free Cajun Seasoning no open date 1 container of Bay Leaves no open date 1 container of Lemon Pepper no open date 1 container of Rubbing Sage no open date 1 container of Thyme Leaves no open date 1 container of Whole Rosemary no open date 1 container of Garlic Powder no open date 2 containers of Salt Free Pepper no open date 1 container of Cinnamon no open date 1 container of Ground Pepper no open date 1 container of Fajita Seasoning no open date 1 container of Paprika no open date 1 bottle of Vanilla Extract no open date The corrective action taken immediately was that all items were dated on the date	

	During an interview on 12/26/24 at 9:45 A.M., the Dietary Manager indicated that all containers should have an open date. She also indicated that food container should be labeled and dated. Leftovers that are dated for residents should only be kept for 3 days. During an interview on 12/27/24 at 11:45 A.M., the Dietary Manager indicated that hands should be washed for at least 20 seconds with soap and water and that no one touch the inside rim of a plate when serving. On 12/30/24 at 1:47 P.M., the Director of Nursing (DON) provided a current non-dated policy "Food Safety and Sanitation". The policy indicated "... when a package is opened, the food item should be marked to indicate the open date. This date is used to determine when to discard the food. Leftovers are to be used with 72 hours (or discarded) ..."		of findings. Action to prevent other items from falling under same deficiency was that Audit Tool was created to inspect all items on spice rack. Ensured all items are marked to indicate open dates. The corrective action put in place to ensure deficient practice does not recur in the future is that dietary staff will be in-serviced on Food Safety and Sanitation Policy. Quality Assurance Tool was put in place for Dietary Manager or designee to inspect each shift for 7 days, then daily for 7 days, then 3 times weekly for 7 days, then 2 times weekly for 7 days, then weekly for 7 days, then monthly to ensure all items are labeled and marked to indicate open dates. The Dietary Manager will keep a binder of daily/weekly checks. Observation resident refrigerator in dining room: 1 can of cola with no name 1 container of red colored fluid with no name or open	

	On 12/30/24 at 1:47 P.M., the DON provided a current, non-dated policy "Handwashing/Hand Hygiene." The policy indicated "... employees must wash their hands for forty-sixty seconds using an antimicrobial or non-antimicrobial soap and water under the following conditions: ... before and after eating or handling food..." Based on observation, record review, and interview, the facility failed to ensure food was stored and served appropriately for 1 of 2 kitchen observations. Food was not labeled in reach in freezer, spices not labeled in the spice rack, resident refrigerator had unlabeled food, and food servers did not wash hands for the appropriate length of time. (kitchen, dining room) Findings included: On 12/26/24 at 9:20 A.M., during a tour of the kitchen the following was observed in the reach in freezer: 1 bottle of Sweet Baby Rays no open date with food build up on the neck of bottle 3 bottles of brown liquid containers no open date 2 cans of whipped cream with no open date At 9:40 A.M., in the blue spice		date 1 Styrofoam container with [resident name] with date 12/23 5 containers of orange-colored liquids no name or dated Inside of refrigerator had spots of brown liquid splattered about the inside of top freezer The corrective action taken immediately was that all items with no name or date was disposed of immediately on date of findings. Action to prevent other items from falling under same deficiency was that Audit Tool was created to inspect all items in resident refrigerator. Ensured all items included name and date. Inside of refrigerator inspected to ensure it was clean and free of splatters. The corrective action put in place to ensure deficient practice does not recur in the future is that dietary staff will be in-serviced on the Food Safety and Sanitation Policy. Quality Assurance Tool put in place for Dietary Manager or designee to inspect each shift for 7 days,	

	rack next to the silver preparation table the following was observed: 1 container of beef paste no open date 1 container of Chile Powder no open date 1 container of Lowery Season Salt no open date 1 container of Corn Starch no open date 1 container of Bayside Seasoning no open date 1 container of Salt free Cajun Seasoning no open date 1 container of Bay Leaves no open date 1 container of Lemon Pepper no open date 1 container of Rubbing Sage no open date 1 container of Thyme Leaves no open date 1 container of Whole Rosemary no open date 1 container of Garlic Powder no open date 2 containers of Salt Free Pepper no open date		then daily for 7 days, then 3 times weekly for 7 days, then 2 times weekly for 7 days, then weekly for 7 days, then monthly to ensure all items are labeled, marked to indicate open dates, and areas are clean and sanitary. The Dietary Manager will keep a binder of daily/weekly checks. Observation dietary cook washed hands for 5 seconds in sink with soap and water before taking food temperature: Action to prevent same deficiency from reoccurring was that Audit Tool was created to observe if staff are sanitizing and washing hands according to Infection Control and Hand Washing Policy. The corrective action put in place to ensure deficient practice does not recur in the future is that dietary staff will be in-serviced on Hand Washing/Hand Hygiene Policy. Quality Assurance Tool was put in place for Dietary Manager or designee to observe on each shift for 7 days, then daily for	

	1 container of Cinnamon no open date 1 container of Ground Pepper no open date 1 container of Fajita Seasoning no open date 1 container of Paprika no open date 1 bottle of Vanilla Extract no open date At 9:45 A.M., the following was observed in the Resident Refrigerator in the Dining Room: 1 can of cola with no name 1 container of red colored fluid with no name or open date 1 Styrofoam container with [resident name] with date 12/23 5 containers of orange-colored liquids no name or dated Inside of refrigerator had spots of brown liquid splattered about the inside of top freezer On 12/27/24 at 11:45 A.M., during a random observation of lunch the following was observed: Dietary cook washed hands for 5 seconds in sink with soap and water before taking the food temperature.		7 days, then 3 times weekly for 7 days, then 2 times weekly for 7 days, then weekly for 7 days, then monthly to ensure all staff are following Handwashing/Hand Hygiene Policy. The Dietary Manager will keep a binder of daily/weekly checks. Observation Dietary cook touched inside rim of plate; kitchen volunteer touched inside rim while serving a resident their meal: The corrective action taken immediately was Dietary Manager gave instruction to all dietary staff with practice indicating correct way to handle plate by carrying on palm with hand flat. Action to prevent reoccurrence of same deficiency was that Audit Tool was created to observe if staff are following proper food handling procedures to ensure that they are not touching the inside rim of the plate when delivering or plating meals. The corrective action put in place to ensure deficient practice does not recur	

	Dietary cook touched the inside rim of the plate when plating 2 meals for residents Kitchen Volunteer touched the inside rim while serving a resident their meal. During an interview on 12/26/24 at 9:25 A.M., the Dietary Manager indicated the creamers were here and should have had her name and open date on the creamers. During an interview on 12/26/24 at 9:45 A.M., the Dietary Manager indicated that all containers should have an open date. She also indicated that food container should be labeled and dated. Leftovers that are dated for residents should only be kept for 3 days. During an interview on 12/27/24 at 11:45 A.M., the Dietary Manager indicated that hands should be washed for at least 20 seconds with soap and water and that no one touch the inside rim of a plate when serving. On 12/30/24 at 1:47 P.M., the Director of Nursing (DON) provided a current non-dated policy "Food Safety and Sanitation". The policy indicated "... when a package is opened, the food item should be marked to indicate the open date. This date is used to determine when to discard the food. Leftovers are to be used with 72 hours (or		in the future is that dietary staff will be in-serviced on proper food handling procedures. Quality Assurance Tool was put in place for Dietary Manager or designee to observe each shift for 7 days, then daily for 7 days, then 3 times weekly for 7 days, then 2 times weekly for 7 days, then weekly for 7 days, then monthly to ensure all staff are following proper food handling procedures by not touching the inside rim of plate when delivering or plating meals. The Dietary Manager will keep a binder of daily/weekly checks.	

	discarded) ..." On 12/30/24 at 1:47 P.M., the DON provided a current, non-dated policy "Handwashing/Hand Hygiene." The policy indicated "... employees must wash their hands for forty-sixty seconds using an antimicrobial or non-antimicrobial soap and water under the following conditions: ... before and after eating or handling food..."			
R 0306	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(g)(1-9) (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal.	R 0306	R306 By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 2/15/2025. The facility requests that this Plan of Correction and items submitted be considered for desk review and paper compliance.	02/15/2025

	(8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on observation, record review, and interview, the facility failed to ensure proper storage of medication in 3 of 6 medication carts reviewed. (600 Floor Medication Cart 1,600 Floor Medication Cart 2, 300 Floor Medication Cart) Findings included: On 12/26/24 at 10:20 A.M., during a random observation of Medication Cart 1 for the 600 Floor the following loose pill were observed: 1 round yellow pill with number 161 ½ white round pill no number 1 small round pill number 2621 3 ½ white oblong pills 1 orange square pill with no number 1 large white with number 210 1 green oblong pill with no number 1 small round brown pill with no number		Observation failure to ensure proper medication storage On 12/26/24 at 10:20 A.M., during a random observation of Medication Cart 1 for the 600 Floor the following loose pill were observed: 1 round yellow pill with number 161 ½ white round pill no number 1 small round pill number 2621 3 ½ white oblong pills 1 orange square pill with no number 1 large white with number 210 1 green oblong pill with no	

2 large white pills with no numbers

1 bottle of Cinacalcet 90 mg - no name or label

300 Floor Medication Cart:

1 round blue pill with no number

1 round large pill with no number

1 bottle of Magnesium 250 mg with no label or open date, black marker [patient name]

1 bottle of Calcium 600 mg with no label or open date, black marker [patient name]

Medication Cart Number 2 600 Floor:

1 oval beige colored

1 blue capsule

1 large white round with # pila 430

1 blue oblong

During an interview on 12/26/24 at 10:35 A.M., Qualified Medicine Aide (QMA) 7 indicated there should be no loose pills and the bottles should have a label and open date.

During an interview on 12/30/24 at 2:10 P.M., the Director of Nursing (DON) indicated the DON indicated the facility did

number

1 small round brown pill with no number

2 large white pills with no numbers

1 bottle of Cinacalcet 90 mg - no name or
label

300 Floor Medication Cart:

1 round blue pill with no number

1 round large pill with no number

1 bottle of Magnesium 250 mg with no label or

open date, black marker [patient name]

1 bottle of Calcium 600 mg with no label or
open

not have a policy related to lose pills, but staff should dispose of any loose pills observed in the medication carts.

Based on observation, record review, and interview, the facility failed to ensure proper storage of medication in 3 of 6 medication carts reviewed. (600 Floor Medication Cart 1,600 Floor Medication Cart 2, 300 Floor Medication Cart)

Findings included:

On 12/26/24 at 10:20 A.M., during a random observation of Medication Cart 1 for the 600 Floor the following loose pill were observed:

1 round yellow pill with number 161

½ white round pill no number

1 small round pill number 2621

3 ½ white oblong pills

1 orange square pill with no number

1 large white with number 210

1 green oblong pill with no number

1 small round brown pill with no number

2 large white pills with no numbers

date, black marker [patient name]

Medication Cart Number 2 600 Floor:

1 oval beige colored

1 blue capsule

1 large white round with # pila 430

1 blue oblong

The corrective action taken immediately: The facility does provide and ensure proper medication storage. Medications are checked in and reconciled upon pharmacy delivery by licensed nursing staff to ensure proper storage. Medication cart audits are conducted by licensed nursing staff or QMA daily to monitor medication storage and identify/remove any loose pills observed to ensure ongoing compliance.

	1 bottle of Cinacalcet 90 mg - no name or label 300 Floor Medication Cart: 1 round blue pill with no number 1 round large pill with no number 1 bottle of Magnesium 250 mg with no label or open date, black marker [patient name] 1 bottle of Calcium 600 mg with no label or open date, black marker [patient name] Medication Cart Number 2 600 Floor: 1 oval beige colored 1 blue capsule 1 large white round with # pila 430 1 blue oblong During an interview on 12/26/24 at 10:35 A.M., Qualified Medicine Aide (QMA) 7 indicated there should be no loose pills and the bottles should have a label and open date. During an interview on 12/30/24 at 2:10 P.M., the Director of Nursing (DON) indicated the DON indicated the facility did not have a policy related to lose pills, but staff should dispose of		Action taken to prevent same deficiency: All RWC Licensed Nurse and QMA staff received in-service training on proper medication storage on 1/17/25. The corrective action put in place to ensure deficient practice does not recur in the future is that audits of medication carts for proper medication storage will be completed by licensed nurse or DON 5 times/week X 2 months, then 3 times/week X 2 months, then weekly X 2 months to ensure on-going compliance. Audit results will be reviewed and monitored monthly in QA meeting.	

	any loose pills observed in the medication carts.			

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