STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVER CROSSING ASSISTED LIVING COMMUNITY	2400 MARKET ST CHARLESTOWN, IN 47111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00451845 and IN00452326. Complaint IN00451845 - No deficiencies related to the allegations are cited. Complaint IN00452326 - State deficiency related to the allegations is cited at R0029. Survey date: February 13, 14 and 17, 2025 Facility number: 012007 Residential Census: 68 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on February 21, 2025.	R 0000		
R 0029 Bldg. 00	410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency Based on observation, interview and record review, the facility failed to ensure resident's (Resident C and Resident E) were treated with respect and dignity for 2 of 3 residents reviewed for resident rights. Findings include: 1. The clinical record for Resident C was reviewed on 2/13/25 at 11:25 a.m. The resident's diagnoses included, but were not limited to, left-sided hemiplegia, obsessive compulsive disorder, depression, and attention-deficit hypersensitivity disorder.	R 0029	1.) All group text messages have been limited to staffing needs or reminders to check communication log or for upcoming meetings 2.) All residents have the potential to be affected by the alleged deficient practice. 3.) Nursing Staff were educated on communication protocols including proper use of text messaging, proper use of communication log by 3/12/2025 4.) ED to be included on all group	03/14/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
RICHARD PEDERSEN	Executive Director	03/07/2025

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	During an interview on 2/13/25 at 1:00 p.m., Resident C's family member indicated he was given a screen shot copy of the texted group chat between Employee 3, Employee 4, and Employee 5. The group chat indicated his family member was stupid and ignorant. The texted group chat screen shot was reviewed on 2/13/25. The screen shot of the text messages between Employee 4, Employee 5, and Employee 3's indicated the following: Employee 5 texted that she told Resident C to stay in her own business because she was not Resident E's Power of Attorney. Employee 3 responded, thank you and that Resident C was just stupid. Employee 5 texted that Resident C said she's going to find new placement. Employee 3 responded that she didn't care what Resident C or Resident E said, they were ignorant. 2. The clinical record for Resident E was reviewed on 2/14/25 at 10:22 a.m. The resident's diagnoses included, but were not limited to, anxiety, alcohol abuse, depression, and post-traumatic stress disorder. During an interview on 2/13/25 at 1:00 p.m., another resident's family member indicated he was given a screen shot copy of the employee texted group chat. The group chat had negative comments about Resident E and his family member. The texted group chat screen shot was reviewed on 2/13/25. The screen shot of the text messages between Employee 4, Employee 5, and Employee 3's indicated the following: Employee 4 texted that Resident E was going around in the living area and told another resident that he was being kicked		texts to allow monitoring of proper use of text messaging. ED/Designee will review text messages and log compliance weekly for 4 months. ED/Designee will review with QA Committee. QA Committee will determine if audits necessitate extension longer than 4 months and will continue to review audit results monthly for duration of the extended timeframe as applicable.	

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	out without a 30-day notice and his family member just stood there. Employee 3 responded she didn't care what Resident C or Resident E said, they were all ignorant. That was why Resident E acted like he did because his family member never whipped his a**. The text message was followed by two laughing emojis. During an interview on 2/17/25 at 9:29 a.m., the Executive Director (ED) indicated staff should not text resident specific information. The staff should only text amongst themselves information regarding staff coverage or to check the communication log, which was established related to the text messages in question. The verbiage in the text messages were inappropriate and part of the issue of why changes were made as to what could be texted between the staff. On 2/17/25 at 10:35 a.m., the ED provided a current, undated copy of the document titled "Resident Rights". It included, but was not limited to, "Federal and state laws guarantee certain basic rights to all residents of this facility...facility will make every effort to assist each resident in exercising his or her rights to assure that the resident is always treated with respect, kindness and dignity...." This State Citation relates to Complaint IN00452326			