STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155106	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVERWALK VILLAGE	295 WESTFIELD RD NOBLESVILLE, IN 46060

(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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00423551 and IN00423956. Complaint IN00423551 - No deficiencies related to the allegations are cited. Complaint IN00423956 - No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey dates: 1/2/24 - 1/3/24 Facility number: 000044 Provider number: 155106 AIM number: 100274940 Census Bed Type: SNF/NF: 114 Total: 114 Census Payor Type: Medicare: 4 Medicaid: 68 Other: 42 Total: 114 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 8, 2024.	F 0000	**Please accept our Plan of Correction (POC) from the complaint survey conducted at Riverwalk Village on 01/02/2024. We respectfully request a desk review in this matter. Thank you for your consideration.**	
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must -			

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

Adam McGraw | Executive Director | 01/17/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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	(X3) DATE SURVEY COMPLETED
	155106	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVERWALK VILLAGE	295 WESTFIELD RD NOBLESVILLE, IN 46060

(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
	§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to ensure meal service was completed in a sanitary manner for 3 of 3 residents reviewed for dietary services. (Residents H, J, and K) Findings include: The following was observed on 1/2/24 at 12:26 p.m.: LPN 4 picked up the top bun from Resident H's sandwich, in her ungloved hand, to place tartar sauce on top of the fish. LPN 4 replaced the bun and moved the plate in front of Resident H and returned to the cafeteria window to collect the next tray. LPN 4 picked up the top bun from Resident J's sandwich, in her ungloved hand, to place tartar	F 0812	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - Resident E was found not to be affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** - All residents have the same potential to be affected by this alleged deficient	01/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155106	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVERWALK VILLAGE	295 WESTFIELD RD NOBLESVILLE, IN 46060

(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
	sauce on top of the fish. LPN 4 replaced the bun on the plate in front of Resident J and returned to the cafeteria window to collect the next tray. LPN 4 picked up the top bun from Resident K's sandwich, in her ungloved hand, to place tartar sauce on top of the fish. LPN 4 replaced the bun on the plate in front of Resident K. 1. Resident H's clinical record was reviewed on 1/3/24 at 10:05 a.m. Diagnosis included type 2 diabetes mellitus, chronic viral hepatitis C, and thrombocytopenia. A current physician's order, dated 5/31/23, indicated Resident H had a regular diet. 2. Resident J's clinical record was reviewed on 1/3/24 at 10:05 a.m. Diagnosis included heart failure, myasthenia gravis and hypertension. A current physician's order, dated 12/3/22, indicated Resident J had a no salt added, ground meat diet. 3. Resident K's clinical record was reviewed on 1/3/23 at 10:05 a.m. Diagnosis included peripheral vascular disease, hypertension and chronic kidney disease. A current physician's order, dated 5/22/23, indicated Resident K had regular diet. During an interview on 1/3/24 at 11:58 a.m., the DON indicated staff had informed her, last night, of the mistakes noted during the lunch observation and her expectation was for staff to not touch food with a bare hand and to don a glove, or to use a fork or napkin, to remove the tops of sandwiches when helping residents at		practice. - All staff have been educated on 01/10/24 by the Executive Director/DNS on food preparation and handling. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** - All staff were educated on 01/10/24 by the Executive Director/DNS on food preparation and handling. - Dining Observational tool will be completed daily by Executive Director/designee x6 weeks and until compliance is maintained. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** - Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. - POC QAPI tool identified will be completed at variant meals,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155106	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVERWALK VILLAGE	295 WESTFIELD RD NOBLESVILLE, IN 46060

(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
	meal times. A current facility policy, revised 6/23, titled "General Food Preparation and Handling," provided by the Administrator on 1/3/24 at 2:00 p.m. indicated the following: "... 3. Bare hands should never touch raw or ready to eat food directly. Food will be prepared and served with clean tongs, scoops, forks, spoons, spatulas, or other suitable implements to avoid bare hand contact of foods...." 3.1-21(i)(3)		in variant dining rooms weekly x 4 weeks, monthly x 5 months, and quarterly thereafter until compliance is achieved. - If Threshold of 95% is not met, an action plan will be developed to ensure compliance.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155106	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVERWALK VILLAGE	295 WESTFIELD RD NOBLESVILLE, IN 46060

(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
	§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155106	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVERWALK VILLAGE	295 WESTFIELD RD NOBLESVILLE, IN 46060

(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
	of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure personal protective equipment (PPE) was worn during patient care for 1 of 3 residents with COVID-19 infection reviewed for infection control. (Resident E) Findings include: During an observation and interview, on 1/2/24 at 11:57 a.m., the Resident E's door was open and NA 1 was bent over, assisting the resident. NA 1 did not have on a gown, gloves, or face shield. Upon exiting the room, NA 1 indicated the droplet isolation sign located on outside the resident's room instructed what PPE she should have worn before entering the room to assist this resident. Resident E's clinical record was reviewed on 1/3/24 at 10:45 a.m. Diagnosis included chronic obstructive pulmonary disease (COPD), morbid obesity, and COVID-19. Current physician orders, dated 12/28/23 at 11:48 a.m., indicated, due to having an active infection with highly transmissible pathogens, this resident required droplet isolation related to signs and symptoms of COVID-19. During a follow up interview, on 1/3/24 at 11:58 a.m., the DON indicated the expectation was for staff to don PPE prior to entry and doff the PPE upon exiting the resident's room, per the instructions on the droplet isolation sign.	F 0880	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - Residents H, J, and K were found not to be affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** -All residents have the same potential to be affected by this alleged deficient practice. -All staff have been educated on 01/10/24 by the Executive Director/DNS on **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;**	01/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155106	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVERWALK VILLAGE	295 WESTFIELD RD NOBLESVILLE, IN 46060

(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
	Review of a current, revised policy, reviewed September 2023, titled "Standard and Transmission- Based Precautions (Isolation) Policy," provided by the Administrator on 1/2/24 at 2:45 p.m., indicated the following: "...Droplet Precautions: refers to actions designed to reduce/prevent the transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. ...Use of Personal Protective Equipment- Mask and face protection in addition to gown and gloves:..." 3.1-18(a)		-All staff were educated on 01/10/24 by the Executive Director/DNS on infection prevention and control. -Residents in isolation will be discussed in morning meeting and communicated at GEMBA. -PPE Observational tool will be completed daily by IP/designee x6 weeks and until compliance is maintained. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** -Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. -POC QAPI tool identified will be completed weekly x 4 weeks, monthly x 5 months, and quarterly thereafter until compliance is achieved. -If Threshold of 95% is not met, an action plan will be developed to ensure compliance.	