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	08/29/2022

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00382938, IN00388110, and IN00388161. This visit was in conjunction with the Investigation of Complaint IN00388582. Complaint IN00382938 - Substantiated. Federal/State deficiencies related to the allegations are cited at F550 and F677. Complaint IN00388110 - Substantiated. Federal/State deficiencies related to the allegations are cited at F550, F558, F677, and F725. Complaint IN00388161 - Substantiated. Federal/State deficiencies related to the allegations are cited at F550, F558, F677, and F725. Complaint IN00388582 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: August 22, 23, 24, 25, 26, and 29, 2022. Facility number: 000044 Provider number: 155106 AIM number: 100274940 Census Bed Type: SNF/NF: 131 Total: 131 Census Payor Type: Medicare: 8 Medicaid: 68	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review on or after September 28, 2022.	

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

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	Other: 55 Total: 131 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 2, 2022.			
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.			

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	§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to ensure privacy was maintained for a terminal resident (Resident 106), dining was provided in a dignified manner to dependent residents (Resident 29 and 59), a resident did not wear a security bracelet without indication (Resident 39), and care was provided in accordance with social norms for a dependent resident (Resident G) for 5 of 5 residents reviewed for dignity (Residents 106, 29, 59, 39 and G). Findings include: 1. During an observation, on 8/22/22 at 2:22 p.m., Resident 106's door was open. The resident was lying in her bed with her eyes closed, her nasal cannula was in her hand at her side, and her gown was pulled down around her waist leaving her breasts exposed. The resident's bed was the first bed encountered upon entry to the room. The privacy curtain was pulled halfway between the resident and her roommate, but not between the resident and entry into the room. The resident's roommate was required to pass by the resident to get to her own area of the room. The Floating Director of Nursing Services (DNS) was notified and provided care. The resident's gown and nasal cannula were placed appropriately. Curtain positioning remained unchanged, and the room	F 0550	p="" paraid="1287006091" paraeid="{e36e8806-8541-41c1-8642-d33e891fc3d6}{17}">What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Identifier list was not provided. All measures below were completed for all residents including 106, 29, 59, and G. Resident 39 security bracelet was removed p="" paraid="6970550" paraeid="{e36e8806-8541-41c1-8642-d33e891fc3d6}{37}">How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by this deficient practice Staffing patterns reviewed and adjusted. Call lights reviewed for placement and function for every resident Residents with reviewed by Social Services. Residents with catheters reviewed for appropriate placement. All staff re-educated	09/28/2022

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	door remained open following the resident's care. During an observation, on 8/23/22 at 8:41 a.m., the resident's door was open. The resident was lying in her bed, eyes closed, and her breasts were exposed as her gown was around her waist. The privacy curtain was pulled halfway between the resident and her roommate, but not between resident and entry into room. During an observation, on 8/23/22 at 10:46 a.m., the resident's door was open. The resident was lying in her bed with eyes closed, gown down around her waist leaving her breasts exposed. The privacy curtain was pulled halfway between the resident and her roommate, but not between the resident and entry into the room. Certified Nurse Aide 71 was notified and provided care. The resident's gown and blankets were adjusted to cover resident. The privacy curtain positioning remained unchanged. The door to the room remained open. During an observation, on 8/24/22 at 8:49 a.m., the resident's door was open. The privacy curtain was open between the entry into room and the resident. The resident was lying in the bed with eyes closed. The resident's sheet was pulled up over the resident's shoulders . The resident's clinical record was reviewed on 8/24/22 at 9:55 a.m. Diagnoses included, but were not limited to, chronic diastolic congestive heart failure, unspecified dementia, need for assistance with personal care, anxiety disorder and pain. The resident was admitted to hospice on 8/11/22 for end stage congestive heart failure. Physician's orders included, but were not limited		on Resident rights. A daily rounding tool reviewing Residents Rights including call lights, dignity/privacy, and catheter tubing to be utilized by Care Companions/Department Managers. p="" paraid="626972681" paraeid="{e36e8806-8541-41c1-8642-d33e891fc3d6}{74}">What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? DNS/Designee will conduct an in-service with all staff on Resident Rights Care Companions will ensure call light clips placed on call lights for all residents.Residents with to be reviewed by SS/designee for appropriate placement. Social Services/designee to interview all residents regarding shower preferences and shower schedule to be updated according to preferences noted.All staff re-educated on placement of catheter tubing by DNS/designee. A daily rounding tool reviewing Residents Rights including call lights, dignity/privacy, and catheter tubing to be utilized by Care Companions/Department Managers. p="" paraid="989404528" paraeid="{e36e8806-8541-41c1-8642-d33e891fc3d6}{121}">How the corrective action (s) will be	

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	to, lorazepam intensol (antianxiety) 2 milligram(mg)/milliliter (mL): 0.25 mL every 6 hours (8/12/22), lorazepam intensol 2 mg/mL: 0.5 mL every 4 hours as needed for agitation/anxiety/restlessness (8/12/22), morphine concentrate 100 mg/5 mL: 5 mg as needed every 4 hours as needed for air hunger/pain (8/15/22), and oxygen at 2 liters per minute per nasal cannula to keep oxygen saturation above 90%. A hospice care plan initiated on 8/12/22 indicated the goal was for the resident to experience death with dignity and physical comfort. A progress note, dated 8/17/22 at 4:16 a.m., indicated the resident frequently removed her oxygen and linens. A progress note, dated 8/19/22 at 2:40 a.m., indicated the resident frequently removed her oxygen and clothing. A progress note, dated 8/24/22 at 7:53 a.m., indicated the resident often took off her clothes and oxygen. During an interview, on 8/23/22 at 10:48 a.m., CNA 71 indicated the resident was continually pulling down her gown. She indicated she tried to check on resident frequently to pull up gown. During an interview, on 8/23/22 at 11:12 a.m., CNA 71 indicated the resident pulled down her gown repeatedly. She indicated the son and nurses were all aware of this. She indicated she did not know of anything else that could be done to provide privacy for the resident.2. On 8/23/22 at 8:40 a.m., Resident 39 was at a table in the small dining room, seated in her wheelchair. At 9:49 a.m., she remained in the same place in the dining room. She		monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

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had a security bracelet on her ankle.

On 8/23/22 at 9:58 a.m., she was sitting in her wheelchair in her darkened room.

On 8/23/22 at 10:37 a.m., she was asleep in her wheelchair during an exercise activity.

On 8/23/22 at 3:03 p.m., she was asleep in her wheelchair in the small dining room.

On 8/24/22 at 10:08 a.m., she was asleep in her wheelchair in the small dining room.

On 8/25/22 at 10:16 a.m., she was sitting in her wheelchair in the small dining room. She remained there at 10:39 a.m.

On 8/25/22 at 1:51 p.m., she was seated in her wheelchair, asleep, during a painting activity.

Resident 39's clinical record was reviewed on 8/23/22 at 9:15 a.m. Diagnoses included, but were limited to, Alzheimer's disease and cognitive communication deficit.

The clinical record lacked a physician order for a security bracelet.

She had a current care plan problem, reviewed 7/26/22, of a history of getting up and wandering down the hall and into other resident rooms.

The resident's care plan did not include the use of a security bracelet.

During an interview, on 8/26/22 at 11:20 a.m., RN 40 indicated the resident had a security bracelet because she wandered about the unit at times. She was not aware of her ever exit-seeking from

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	the facility. She would expect a need for a physician's order for the use of a security bracelet and it should be added to the care plan. During an interview, on 8/29/22 at 9:34 a.m., the Float DON indicated security bracelet use required a physician order and use should be in the resident's care plan. During an interview, on 8/29/22 at 9:43 a.m., the Interim Administrator indicated she had located in the clinical record where the security bracelet had been discontinued in March 2022, although it had not been removed until 8/26/22. 3. On 8/23/22 at 10:11 a.m., Resident 29 was in her room, seated in her recliner. On 8/24/22 at 8:44 a.m., she was seated in her wheelchair in her room with her breakfast tray covered on table in front of her. On 8/24/22 at 1:06 p.m., she was seated in her room with her covered lunch tray on the table in front of her. She was reaching for the table, and rocking it, repeatedly stating "help me, please." On 8/24/22 at 1:13 p.m., CNA 31 was walking down the hallway and indicated to another staff member she was going to go feed Resident 29. On 8/25/22 at 8:49 a.m., she was in bed, awake. On 8/25/22 at 10:35 a.m., she was up in her wheelchair in her room with CNA 31 at her bedside situating her. On 8/25/22 at 11:09 a.m., the resident was seated in the small dining room Activity Aide 33. She asked the aide if she would be able to eat out there in			

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	the dining room. The aide indicated she would have to ask but was sure it would be okay. On 8/26/22 at 9:28 a.m., she was in the small dining room for breakfast. She had a palm splint present to her left hand. Her meal was in front of her, with her spoon in the food on the left side. She was asking "help me please, help me." One staff member was seated at the table, assisting a resident on the opposite side of the tables. QMA 35 later entered the dining area and stood to the resident's left side and offered a bite of food, then walked away. The QMA returned with a chair and sat to the resident's left side and began assisting her with her meal. Resident 29's clinical record was reviewed on 8/22/22 at 1:45 p.m. Diagnoses included, but were not limited to, cerebrovascular accident with left sided hemiparesis or hemiplegia and dysphasia. Current physician orders included, but were not limited to, regular pureed diet with honey thick/moderately thick liquids and nurse to ensure resident is up in chair and out to dining room for every meal to decrease risk for aspiration. She had a current care plan problem, reviewed 7/7/22, of impaired mobility related to left hand contracture and left hemiplegia. She had a current care plan problem, reviewed 7/19/22, of risk for altered nutritional status due to feeding tube and mechanically altered diet. Interventions included, but were not limited to, (12/30/21) up for meals in the small dining room for assistance. 4. On 8/24/22 at 8:40 a.m., Resident 59 was in bed, eating breakfast.			

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	On 8/24/22 at 8:55 a.m., he was yelling for help from his bed. He indicated he felt "lousy" and couldn't find his call light. The cord for the standard button-type call light was running from the wall port and underneath the resident's body, under his head, and then over the pillow behind his head. His breakfast was on an over-bed table, which was leaning heavily to the resident's left, causing the food and a full juice glass to slide toward the edge of the table. He had a whole fried egg laying on his chest and food on his blanket. His urinary catheter drainage bag was hooked to the foot of the bed with urine and sediment backed up in the tubing. During an interview, on 8/24/22 at 9:05 a.m., QMA 36 indicated the resident should have his call light in reach at all times and his urinary drainage bag should be below the level of his bladder. On 8/24/22 at 10:38 a.m., he was in bed and the standard button-type call light on the floor next to his bed. During an interview, immediately following the observation, LPN 37 indicated the resident's call light should be in reach and would be placed near him. On 8/24/22 at 11:02 a.m., the resident was in bed and the call light remained in the same place on the floor. During an interview, on 8/24/22 at 11:05 a.m., CNA 31 indicated the resident should have his call light in reach. She was not sure if he was to have a different type of call light than the standard button type. On 8/25/22 at 1:48 p.m., the resident was sitting up in his wheelchair with the call light on the floor			

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	behind the wheelchair. His catheter drainage tubing ran from his right pant leg to the drainage bag, with the tubing touching the floor. The resident indicated he wanted to move and needed help. He could not locate his call light. During an interview, following the observation, CNA 34 indicated the resident didn't get out of bed daily, so he was probably uncomfortable in the wheelchair. His call light should be kept in reach at all times, but he would throw it at times. His tubing should absolutely not be on the floor, but it maybe had an inch before it touched. The resident's leg was higher on the foot pedal of the wheelchair during the interview with the CNA. On 8/25/22 at 3:22 p.m., he was in bed, with the frame low to the ground. His urinary drainage bag was hooked to the side of the bed, causing the tubing to coil on the floor. Resident 59's clinical record was reviewed on 8/23/22 at 12:18 p.m. Diagnoses included, but were not limited to, urinary tract infection (UTI), chronic systolic heart failure, Friedreich ataxia, dysphagia following TIA, and obstructive and reflux uropathy. He had current physician orders for, but not limited to, soft-touch call light (7/8/22) and regular mechanical soft diet with ground meat, no high potassium foods and fried eggs and prune juice at breakfast (7/28/22). He had a current care plan problem, reviewed 8/19/22, for risk for aspiration related to dysphagia. A current, 8/19/22, care plan problem indicated he had a UTI.			

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	He had a current care plan problem, reviewed 8/19/22, of urinary catheter use. Interventions included, but were not limited to, avoid obstructions in the drainage bag and position the bag below the bladder. He had a 8/19/22 care plan problem for risk for altered nutritional status due to readmission to facility, new concerns with confusion, poor intake, and altered texture diet. He required assistance and cuing with meals. A 7/8/22 nutrition note indicated the resident's family requested he receive assistance due to decreased ability to self-feed. 5. On 8/22/22 at 10:37 a.m., Resident G was seated in her room in her wheelchair. She had facial hair present and her hair was disheveled. Activity Aide 33 entered her room and was brushing the resident's hair. She indicated to the resident she needed to have someone shave her facial hair for her and would see if someone could get to it later. On 8/22/22 at 1:28 p.m., she was seated in her wheelchair in her room. She indicated she received a shower maybe once weekly, but couldn't recall the last time she had one. She had no problem with someone shaving her if it was needed. On 8/23/22 at 8:40 a.m., she was in her room with her breakfast tray on the table. She remained in her pajamas and had long facial whiskers and her hair was disheveled and greasy. On 8/23/22 at 10:33 a.m., she was in the main dining room for an activity. She was dressed and the whiskers were still present.			

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	On 8/24/22 at 8:40 a.m., she was in her room with her breakfast tray in front of her. Her hearing aids were hanging from her ears, her eyeglasses were dirty, and the facial hair remained. On 8/24/22 at 10:01 a.m., she was in her room in her wheelchair, chin to chest. She had her pajama pants below her knees and a pair of slacks were on the bed. She remained in the same position at 10:39 a.m. On 8/25/22 at 8:53 a.m., she was in her room in her wheelchair, chin to chest. Her hair was disheveled and the facial hair remained. She was not wearing her glasses or hearing aides. On 8/25/22 at 10:11 a.m., Activity Aide 33 was assisting her with brushing her hair. On 8/25/22 at 8:40 a.m., she was in bed. On 8/26/22 at 9:45 a.m., she was seated in her wheelchair, her slacks pulled to her knees and she was wearing her pajama top. She remained in the same position at 11:00 a.m. Resident G's clinical record was reviewed on 8/22/22 at 2:30 p.m. Diagnoses included, but were not limited to, type 2 diabetes, heart failure, cognitive communication deficit, and lack of coordination. She had a current care plan problem, revised 7/28/22, of required assistance with ADLs. Interventions included, but were not limited to, assist with bathing, showers twice weekly, and partial baths in between. A 7/12/22 care plan for preferences indicated she wanted to be up before breakfast. It was very			

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	important to her to shower twice weekly in the morning. The resident's preference for facial hair was not included in her care plans. During an interview, on 8/25/22 at 11:34 a.m., Unit Manager 39 indicated the resident would refuse to shave her facial hair, but she was not sure if it was included in her care plan. A lot of the facility's women were adamant they didn't need shaved. During an interview, on 8/26/22 at 11:20 a.m., RN 40 indicated the resident probably could physically dress herself, but didn't and staff assisted her with her personal cares. During an interview, on 8/26/22 at 10:27 a.m., CNA 42 indicated she was from an agency and had not worked at the facility before. She would have to look at the resident's care plans or ask someone about the ADL preferences and needs. During an interview, on 8/26/22 at 10:30 a.m., QMA 43 indicated she worked for an agency. She would know how to care for the residents based on shift report and would ask for care sheets. She would set up a resident's meal on their dominant side. She also would consult with the Unit Manager about care preferences. Review of a current facility document titled "Resident Rights..." dated 3/15/17 and provided by the Interim Administrator on 8/25/22 at 2:46 p.m., indicated the following: "...You have a right to a dignified existence, self-determination, and communication with and access to the persons and services inside and outside the facility...Receive the services and/or			

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	items included in the plan of care...You have the right to be treated with respect and dignity...The right to reside and receive services in the facility with reasonable accommodation of your needs and preferences...You have the right to make choices about the aspects of your life in the facility that are significant to you...You have a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely...." 3.1-3(t) This Federal tag relates to Complaints IN00382938, IN00388110, and IN00388161.			
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview, and record review, the facility failed to ensure a resident had access to call lights for 2 of 2 residents reviewed for call light access (Residents Q and 59). Findings include: 1. During an observation, on 8/26/22 at 8:54 a.m., Resident Q was sitting in a specialized chair in his room, his call light was on the floor under his room-mates bed. His clinical record was reviewed on 8/24/22 at 10:31 a.m., Diagnoses included, but were not	F 0558	p paraid="582390365" paraeid="{e36e8806-8541-41c1-8642-d33e891fc3d6}{150}" >What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Facility unable to identify resident due to no identifier list providedAll resident rooms were checked for call lights to ensure placement and function by Care Companion	09/28/2022

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	limited to, history of falling and age-related physical debility. An 8/17/22 significant change MDS (Minimum Data Set) assessment indicated he was cognitively intact. He required extensive assistance with dressing and personal hygiene and was totally dependent with bed mobility, transfers and locomotion on and off the unit. A current care plan, dated 4/30/19, indicated he was at risk for falls. Interventions included, but were not limited to, call light in reach. During an interview, on 8/26/22 at 8:57 a.m., CNA 7 indicated he should have his call light within reach. 2. On 8/24/22 at 8:55 a.m., Resident 59 was yelling for help from his bed. He indicated he felt "lousy" and couldn't find his call light. The cord for the standard button-type call light was running from the wall port and underneath the resident's body, under his head, and then over the pillow behind his head. His breakfast was on an over-bed table, which was leaning heavily to the resident's left, causing the food and a full juice glass to slide toward the edge of the table. He had a whole fried egg laying on his chest and food on his blanket. During an interview, on 8/24/22 at 9:05 a.m., QMA 36 indicated the resident should have his call light in reach at all times. On 8/24/22 at 10:38 a.m., he was in bed and the standard button-type call light on the floor next to his bed. During an interview, immediately following the observation, LPN 37 indicated the resident's call light should be in reach and would be placed near him.		team. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ul class="BulletListStyle1 SCXW20667609 BCX0" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" All residents have the potential to be affected by the alleged deficient practice Care Companion Assignments were reviewed and updated. All resident rooms were checked for call lights to ensure placement and function by Care Companion team/Department Managers. All staff re-educated regarding call lights placement and function. p paraid="1019848513" paraeid="{e36e8806-8541-41c1-8642-d33e891fc3d6}{219}" >What measures will be put into place or what systemic changes you will	

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	On 8/24/22 at 11:02 a.m., the resident was in bed and the call light remained in the same place on the floor. During an interview, on 8/24/22 at 11:05 a.m., CNA 31 indicated the resident should have his call light in reach. She was not sure if he was to have a different type of call light than the standard button type. On 8/25/22 at 1:48 p.m., the resident was sitting up in his wheelchair with the call light on the floor behind the wheelchair. The resident indicated he wanted to move and needed help. He could not locate his call light. During an interview, following the observation, CNA 34 indicated the resident didn't get out of bed daily, so he was probably uncomfortable in the wheelchair. His call light should be kept in reach at all times, but he would throw it at times. Resident 59's clinical record was reviewed on 8/23/22 at 12:18 p.m. Diagnoses included, but were not limited to, urinary tract infection (UTI), chronic systolic heart failure, Friedreich ataxia, dysphagia following TIA, and obstructive and reflux uropathy. He had current physician orders for, but not limited to, soft-touch call light (7/8/22) and regular mechanical soft diet with ground meat, no high potassium foods and fried eggs and prune juice at breakfast (7/28/22). He had a current care plan problem, reviewed 8/19/22, for risk for aspiration related to dysphagia. Review of a current facility document titled "Resident Rights...," dated 3/15/17 and provided		make to ensure that the deficient practice does not recur? DNS/Designee will conduct an in-service with all staff regarding Call lights for residents. ·Call light clips added to all call lights for all residents by Care Companion team ·A daily rounding tool including call light placement to be utilized by Care Companions/Department managers. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ul class="BulletListStyle1 SCXW20667609 BCX0" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter	

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	by the Interim Administrator on 8/25/22 at 2:46 p.m., indicated the following: "...You have a right to a dignified existence, self-determination, and communication with and access to the persons and services inside and outside the facility...Receive the services and/or items included in the plan of care...You have the right to be treated with respect and dignity...The right to reside and receive services in the facility with reasonable accommodation of your needs and preferences...You have a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely...." 3.1-3(v)(1) This Federal tag relates to Complaints IN00388110 and IN00388161.		for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to			

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	inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.			
	Based on interview and record review, the facility failed to ensure a physicians order for code status was in agreement with the residents preference for 2 of 3 residents reviewed for Advanced Directives. (Residents B and 3). Findings include: 1. During an interview, on 8/22/22 at 1:36 p.m., Resident B indicated her preference was not be resuscitated if her heart stopped beating. Her clinical record was reviewed on 8/25/22 at 10:03 a.m. Diagnoses included, but were not	F 0578	p paraid="1429210498" paraeid="{32a9593e-1d95-498c-acca-f8485bcd1f81}{22}" >What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Facility unable to identify resident B and 3 due to no identifier list not providedAn audit regarding code status on all residents was completed by DNS/designee to	09/28/2022

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	limited to, heart failure. A POST (Physician's Order for Scope of Treatment), completed before she had admitted to the facility, indicated a designation of DNR (Do Not Resuscitate). A 7/27/22 quarterly MDS (Minimum Data Set) assessment indicated she was cognitively intact. Her current physician orders included, but were not limited to, a designation of full code. A current care plan, dated 5/23/22, indicated she preferred to be a full code status. The goal indicated her code status would be honored. Interventions included, but were not limited to, advanced directive to be reviewed with resident/legal representative during care conferences and as needed. During an interview, on 8/29/22 at 8:41 a.m., Social Service Director 2 indicted she and the travel DON had met with the resident on 8/26/22 and changed her code status order to reflect her choice to be a DNR. 2. Resident 3's clinical record was reviewed on 8/24/22 at 1:35 p.m. Diagnoses included, but were not limited to, myocardial infarction, atherosclerotic heart disease of native coronary without angina pectoris, essential hypertension and cognitive social or emotional deficit following cerebral infarction. Physician's orders included, but were not limited to, an order dated 5/14/22 for code status: full code (if a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures will be provided to keep them alive). The face sheet indicated the resident was admitted on 5/14/22 and a full code.		determine orders and care plans for all residents. p paraid="1161650784" paraeid="{32a9593e-1d95-498c-acca-f8485bcd1f81}{42}" >How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice ·Audit completed of all residents' code status, care plans and orders to ensure accurate documentation. ·Code status of new admissions and re-admissions to be reviewed during clinical meeting daily for accuracy. ·DNS/Designee will conduct an in-service with all Licensed nursing staff and Social Services staff regarding code status and Post forms. p paraid="700089334" paraeid="{32a9593e-1d95-498c-acca-f8485bcd1f81}{73}" >	

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	The admission agreement, signed by the resident's representative on 5/23/22 at 9:13 a.m., indicated the resident's physician orders for scope of treatment (POST) was provided to the facility for placement in the medical record. An out of hospital do not resuscitate order, signed on 7/26/21 and uploaded to the resident's record on 5/23/22, indicated if the resident experienced cardiac or pulmonary failure in a location other than an acute care hospital, cardiopulmonary resuscitation procedures be withheld or withdrawn and be permitted to die naturally. During an interview, on 8/24/22 at 2:42 p.m., Licensed Practical Nurse (LPN) 72 indicated a resident's code status was listed on their face sheet in the electronic medical record (EMR). During an interview, on 8/24/22 at 3:19 p.m., the SSD indicated she normally readjusts advance directives when a resident is readmitted. She indicated she would typically have a meeting with the family and code status would be addressed. She indicated the family probably decided to make the resident a full code, but she would investigate it further. During an interview, on 8/24/22 at 3:45 p.m., the SSD indicated she looked through the resident's clinical record and the do not resuscitate directive was from the previous stay. She looked over the progress notes and did see where the resident or representative wanted a do not resuscitate order. During an interview, on 8/25/22 at 12:11 p.m., the Floating Director of Nursing Services (DNS) indicated she would check to see with each admission the resident/resident representative		What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? DNS/Designee will conduct an in-service with all Licensed nursing and Social Services staff on resident code status and POST forms. ·Code status to be reviewed on new admissions and re-admissions at clinical meeting daily. ·Code status and POST forms and orders to be reviewed quarterly by with care plan review and as needed with . p paraid="2107705645" paraeid="{32a9593e-1d95-498c-acca-f8485bcd1f81}{117}" > How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter	

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	should provide updated advance directives. She accessed the EMR and indicated the resident's code status was now do not resuscitate and a POST signed 8/25/22 had been added to the resident's record. A current facility policy, revised 2/2020, titled "Advanced Directives Policy" and provided by the administrator on 8/29/22 at 9:43 a.m., indicated " ...If a resident has a valid Advanced Directive, the facility will follow the resident's plan of care to reflect the resident's preferences as expressed in the Directive ..." 3.1-4(f)(5)		for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review and interview, the facility failed to ensure showers or complete bed-baths were provided, per care planned preferences, for 8 of 9 residents reviewed for ADL's (Activities of Daily Living) (Resident's F, Q, D, C, M, K, G and R). Findings include: 1. During an observation, on 8/22/22 at 2:54 p.m., Resident F's hair was greasy with visible dandruff. His clinical record was reviewed on 8/25/22 at 10:55 a.m. Diagnoses included, but were not limited to, vascular dementia without behavioral disturbance.	F 0677	p="" paraid="777627958" paraeid="{32a9593e-1d95-498c-acca-f8485bcd1f81}{155}"> Riverwalk Village respectfully requests additional evidentiary information be considered in eliminating or reducing Federal Tag 677. The current statement of deficiencies on the 2567 omits significant facility information and therefore misrepresents the care and services administered by the provider to its residents. p="" paraid="777627958" paraeid="{32a9593e-1d95-498c-acca-f8485bcd1f81}{155}">What corrective action(s) will be	09/28/2022

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	An 8/9/22 quarterly MDS (Minimum Data Set) assessment indicated he had severe cognitive impairment. He required extensive assistance with transfers and dressing and was totally dependent for personal hygiene and locomotion on and off the unit. A current care plan, dated 2/20/20, indicated he required assistance with ADL's. Interventions included, but were not limited to, assist with bathing as needed per resident preference and offer showers two times per week. Review of a Point of Care History for ADL's, dated 7/1/22 through 7/31/22, indicated out of 93 shifts he had received 32 partial bed-baths, five complete bed-baths, 16 other bed-baths and one shower. Review of a Point of Care History for ADL's, dated 8/1/22 through 8/23/22, indicated out of 69 shifts he had received 23 partial bed-baths, three complete bed-baths, nine other baths and zero showers. During an interview, on 08/25/22 at 9:30 a.m., CNA 20 indicated the resident didn't take showers, wasn't sure why, but he received complete bed-baths. 2. During an interview, on 8/22/22 at 11:01 a.m., Resident Q indicated he didn't know how long it had been since he had a shower. His hair was greasy. His clinical record was reviewed on 8/24/22 at 10:31 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and pain.		accomplished for those residents found to have been affected by the deficient practice? p="" paraid="777627958" paraeid="{32a9593e-1d95-498c-acca-f8485bcd1f81}{155}">Facility unable to identify residents F, Q, D, C, M, K G and R due to no identifier list provided. All residents were interviewed/observed for need of shower on 8/25/22. Showers provided to those residents in need 8/25-8/26/22. p="" paraid="839976749" paraeid="{32a9593e-1d95-498c-acca-f8485bcd1f81}{189}">How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice All residents were re-interviewed by Social Services and Activities to identify their shower preferences. The shower schedule was updated to reflect the preferences of all residents. Preferences to be completed upon admission, quarterly and with . The shower schedule will be updated to reflect residents' wishes. All nursing staff re-educated on resident preferences, documentation of bathing and new schedule by DNS/Designee. The shower schedule will be reviewed daily in clinical and during GEMBA rounds	

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	An 8/17/22 significant change MDS assessment indicated he was cognitively intact. He required extensive assistance with dressing and personal hygiene and was totally dependent with transfers and locomotion on and off the unit. A current care plan, dated 4/30/19, indicated he required assistance with ADL's. Interventions included, but were not limited to, he preferred to have showers in the mornings. Review of a Point of Care History for ADL's, dated 7/1/22 through 7/31/22, indicated out of 93 shifts he had received 33 partial bed-baths, two complete bed-baths, 18 other bed-baths and zero showers. Review of a Point of Care History for ADL's, dated 8/1/22 through 8/23/22, indicated out of 69 shifts he had received 18 partial bed-baths, two complete bed-baths, two other bed-baths and zero showers. 3. During an interview, on 8/22/22 at 10:10 a.m., Resident D indicated he wanted to receive showers but only got bed-baths. His clinical record was reviewed on 8/24/22 at 2:02 p.m. Diagnoses included, but were not limited to, congestive heart failure and diabetes mellitus. A 6/14/22 significant change MDS assessment indicated he was cognitively intact. He required extensive assistance with dressing and personal hygiene and was totally dependent with transfers and locomotion on and off the unit. A current care plan, dated 5/24/21, indicated he required assistance with ADL's. Interventions included, but were not limited to, assist with		with nursing staff. p="" paraid="579921665" paraeid="{32a9593e-1d95-498c-acca-f8485bcd1f81}{224}">What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? All residents were re-interviewed by Social Services and Activities to identify their shower preferences. The shower schedule was updated to reflect the preferences of all residents. Preferences to be completed upon admission, quarterly and with . The shower schedule will be updated to reflect residents' wishes. All nursing staff re-educated on resident preferences, documentation of bathing and new schedule by DNS/Designee. The shower schedule and documentation will be reviewed daily in clinical and during GEMBA rounds with nursing staff. p="" paraid="1297439126" paraeid="{32a9593e-1d95-498c-acca-f8485bcd1f81}{252}">How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement	

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	bathing as needed per resident preference, offer showers two times per week. Review of a Point of Care History for ADL's, dated 7/1/22 through 7/31/22, indicated out of 93 shifts he had received 32 partial bed-baths, zero complete bed-baths, 20 other bed-baths and zero showers. Review of a Point of Care History for ADL's, dated 8/1/22 through 8/23/22, indicated out of 69 shifts he had received 22 partial bed-baths, four complete bed-baths, three other bed-baths and zero showers. 4. During an interview, on 8/23/22 at 10:40 a.m., Resident C indicated she was supposed to have showers twice a week but it had been a long time since her last shower. Her clinical record was reviewed on 8/25/22 at 8:26 a.m. Diagnoses included, but were not limited to, dementia. A 6/16/22 quarterly MDS assessment indicated she had moderate cognitive impairment. She required extensive assistance with transfers, locomotion on and off the unit, dressing and with personal hygiene. A current care plan, dated 4/27/21, indicated she required assistance with ADL's. Interventions included, but were not limited to, assist with bathing as needed per resident preference, offer showers two times per week. Review of a Point of Care History for ADL's, dated 7/1/22 through 7/31/22, indicated out of 93 shifts she had received 29 partial bed-baths, zero complete bed-baths, 18 other bed-baths and one		Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

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	shower. Review of a Point of Care History for ADL's, dated 8/1/22 through 8/23/22, indicated out of 69 shifts she had received 21 partial bed-baths, one complete bed-bath, six other bed-baths and one shower. 5. During an interview, on 8/22/22 at 10:37 a.m., Resident M indicated he was supposed to have a shower twice a week but hadn't had one in about a month. His clinical record was reviewed on 8/25/22 at 8:51 a.m. Diagnoses included, but were not limited to, heart failure and diabetes mellitus. An 8/9/22 annual MDS assessment indicated he was cognitively intact. He required limited assistance with locomotion on and off the unit and extensive assistance with dressing and personal hygiene. A current care plan, dated 12/31/17, indicated he required assistance with ADL's. Interventions included, but were not limited to, he preferred showers twice a week. Review of a Point of Care History for ADL's, dated 7/1/22 through 7/31/22, indicated out of 93 shifts he had received nine partial bed-baths, zero complete bed-baths, 16 other bed-baths and zero showers. Review of a Point of Care History for ADL's, dated 8/1/22 through 8/23/22, indicated out of 69 shifts he had received eight partial bed-baths, zero complete bed-baths, three other bed-baths and zero showers.6. During an interview, on 8/23/22 at 9:03 a.m., Resident K was in his room. His hair			

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	was greasy and his face was unshaved. He indicated he was supposed to receive a shower every Monday and Thursday. He had wanted his shower and a shave yesterday, which was a Monday, but he had been told the facility was too short-staffed, as there were three CNAs for the whole unit. The last time he had been shaved was the previous Thursday. He was incontinent, and would sit in urine for three to four hours at a time, as well as feces. He told staff around 15 minutes ago that he needed incontinence care and Social Services 44 had indicated she would leave his call light on so someone would come help him. He did not get his teeth brushed regularly. A family member had brushed his teeth the previous Saturday. He also had sores on his buttocks, although he had a cushion in his wheelchair. During an observation, on 8/23/22 at 9:23 a.m., the DON responded to the call light and indicated to the resident to "give us a few seconds". He indicated to her he had been incontinent of bowel and needed assistance. She told CNA 34 and the CNA indicated the resident was going to have to give them a few minutes. During an interview, on 8/23/22 at 9:36 a.m., CNA 34 indicated she had not yet gone to get anyone to help the resident with incontinent care, as she was still feeding residents and they were late getting trays. During an interview, on 8/24/22 at 10:03 a.m., the resident was seated in his wheelchair in his room. His right hand was in a flaccid fist. He indicated he had a splint in his room but it had not been applied since three days prior, nor did staff place a washcloth in his right hand. He was only able to use his left hand.			

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	Review of Resident K's clinical record was completed on 8/22/22 at 11:00 a.m. Diagnoses included, but were not limited to, Parkinson's disease, apraxia, right hand contracture, and lymphedema. He had current physician orders for, but not limited to, (6/9/22) hydrophilic wound dressing paste to gluteal fold twice daily for prevention, clean right hand with soap and water, pat dry, and place a rolled up wash cloth in right hand every shift, house moisture barrier cream to buttocks, groin, inner thighs, sacrum, and coccyx every shift, requires assist with ADLs, and transfer with mechanical lift and two staff. A 6/2/22, quarterly, MDS assessment indicated he was cognitively intact and required extensive assistance with ADLs and mobility. He was frequently incontinent of urine and always incontinent of bowel. His range of motion was impaired on one side. He had a current, 8/19/22, care plan problem of natural teeth and risk for impaired dental hygiene. He had a current, 8/19/22, care plan problem of requires assistance with ADLs. Interventions included, but were not limited to, assist with bathing as needed per preference, offer showers twice weekly and a partial bath in between, and wash right hand and place rolled up washcloth in right hand. Review of a 8/23/22 preferences assessment indicated it was very important to him to have a bed bath twice weekly in the morning. Review of shower documentation for July 2022 indicated 26 partial bed baths and five "other"			

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	baths during 93 shifts. Review of shower documentation for August 2022 indicated 30 partial bed baths, 14 "other" baths, and one complete bed bath over 69 shifts through 8/23/22. 7. On 8/22/22 at 10:37 a.m., Resident G was seated in her room in her wheelchair. She had facial hair present and her hair was disheveled. Activity Aide 33 entered her room and was brushing the resident's hair. She indicated to the resident she needed to have someone shave her facial hair for her and would see if someone could get to it later. On 8/22/22 at 1:28 p.m., she was seated in her wheelchair in her room. She indicated she received a shower maybe once weekly, but couldn't recall the last time she had one. She had no problem with someone shaving her if it was needed. On 8/23/22 at 8:40 a.m., she was in her room with her breakfast tray on the table. She remained in her pajamas and had long facial whiskers and her hair was disheveled and greasy. On 8/23/22 at 10:33 a.m., she was in the main dining room for an activity. She was dressed and the whiskers were still present. On 8/24/22 at 8:40 a.m., she was in her room with her breakfast tray in front of her. Her hearing aids were hanging from her ears, her eyeglasses were dirty, and the facial hair remained. On 8/24/22 at 10:01 a.m., she was in her room in her wheelchair, chin to chest. She had her pajama pants below her knees and a pair of slacks were on the bed. She remained in the same position at			

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	10:39 a.m. On 8/25/22 at 8:53 a.m., she was in her room in her wheelchair, chin to chest. Her hair was disheveled and the facial hair remained. She was not wearing her glasses or hearing aides. On 8/25/22 at 10:11 a.m., Activity Aide 33 was assisting her with brushing her hair. On 8/26/22 at 9:45 a.m., she was seated in her wheelchair, her slacks pulled to her knees and she was wearing her pajama top. She remained in the same position at 11:00 a.m. Resident G's clinical record was reviewed on 8/22/22 at 2:30 p.m. Diagnoses included, but were not limited to, type 2 diabetes, heart failure, cognitive communication deficit, and lack of coordination. A 7/12/22, quarterly, MDS assessment indicated she was moderately cognitively impaired and required extensive assistance with ADLs. She was occasionally incontinent of bladder and frequently incontinent of bowel. She had a current care plan problem, revised 7/28/22, of required assistance with ADLs. Interventions included, but were not limited to, assist with bathing, showers twice weekly, and partial baths in between. A 7/12/22 care plan for preferences indicated she wanted to be up before breakfast. It was very important to her to shower twice weekly in the morning. The resident's preference for facial hair care was not included in her care plans.			

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	Review of shower documentation for July 2022 indicated she received 25 partial bed baths, 13 "other" baths, and one complete bed bath during 93 working shifts. Review of shower documentation for August 2022 indicated she received 20 partial bed baths, four "other" baths, and two complete bed baths during 69 working shifts. During an interview, on 8/25/22 at 11:34 a.m., Unit Manager 39 indicated the resident would refuse to shave her facial hair, but she was not sure if it was included in her care plan. A lot of the facility's women were adamant they didn't need shaved. During an interview, on 8/26/22 at 11:20 a.m., RN 40 indicated the resident probably could physically dress herself, but didn't and staff assisted her with her personal cares. During an interview, on 8/26/22 at 10:27 a.m., CNA 42 indicated she was from an agency and had not worked at the facility before. She would have to look at the resident's care plans or ask someone about the ADL preferences and needs. During an interview, on 8/26/22 at 10:30 a.m., QMA 43 indicated she worked for an agency. She would know how to care for the residents based on shift report and would ask for care sheets. She would set up a resident's meal on their dominant side. She also would consult with the Unit Manager about care preferences. 8. On 8/22/22 at 11:10 a.m., Resident R left his room and entered the hallway. He was disheveled, his face was soiled, and he was wearing soiled clothing. His pants were below his			

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	hips, his feeding tube was hanging out, and his brief was obviously soiled. He was asking passerby if they could help him pull his pants up. The Medical Records Nurse assisted him into his room and into the bathroom. During an observation of the resident's bathroom, on 8/22/22 at 11:20 a.m., his bathroom floor was littered with wet paper towels soaked with brown and yellow stains, near the toilet. The toilet had brown smears and yellow stains on the rim. The bathtub was covered with a sheet of plywood and had, but not limited to, a toilet riser with brown smears and a toilet plunger on it. The room smelled strongly of urine. On 8/24/22 at 8:43 a.m., he was eating breakfast in his room. On 8/24/22 at 10:09 a.m., he was sitting on a sofa near Nurse Station 2, holding a cup. His pants were soiled with food and stains. Resident R's clinical record was reviewed on 8/22/22 at 1:45 p.m. Diagnoses included, but were not limited to, dementia, heart failure, and dysphagia. A 8/2/22, quarterly, MDS assessment indicated he was cognitively intact and required extensive assistance with ADLs. He was occasionally incontinent of bladder and frequently incontinent of bowel. He had a current care plan problem, revised 6/5/22, of resident refused a shower. Interventions included, but were not limited to, offer later, offer by different staff, and offer personal space. He had a current care plan problem, revised 6/5/22,			

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	of requires assist with toileting. He had a current care plan problem, revised 6/5/22, of requires assist/monitoring with am/pm care, nutrition, and hydration. Review of an 8/2/22 preferences assessment indicated it was very important for him to have showers twice weekly. During a confidential interview, a nursing department staff member indicated there were three CNAs on day shift for the H, I, J, and K halls (four halls on the south end of the facility) and were unsure if there was a fourth scheduled. The staff member had four showers scheduled to do themselves for the day and were unsure if they would be able to complete them. If showers weren't done, then bed baths would be completed instead. During an interview, on 8/24/22 at 8:49 a.m., CNA 45 indicated they were working with two other CNAs for the H, I, J, and K halls. There was possibly one other CNA working, but they did not know who it was. During an interview, on 8/25/22 8:50 a.m., CNA 31 indicated there were six CNAs working on the south end of the building for day shift. During a confidential interview, Nursing Department Staff Member Z indicated the facility was usually staffed with one CNA per hallway for the H, I, J, and K halls. They tried to get as many residents to the dining room that needed assistance, otherwise, they assisted them in their rooms. They were not always able to give showers, but would try to wash everyone up as much as they could. They would clean the			

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	residents' hair while they were on the toilet and getting cleaned up. During a confidential interview, Nursing Department Staff Member T indicated they needed a minimum of five CNAs to provide care to those on the H, I, J, and K halls. The staffing was hit and miss, there were a lot of call offs, including agency staff. There were probably 30 residents who required the use of two people and/or a mechanical lift for transfers. A lot of the residents needed to be up for meals to eat safely. Shower sheets were supposed to be completed by the CNAs with bathing and turned into the Unit Manager. If the resident refused care, the shower sheet would indicate it and the resident would sign for the refusal. They were not sure if Resident K was supposed to have a splint of washcloth in his hand, but he could ask staff about it himself. During an interview, on 8/25/22 at 2:02 p.m., the Interim Administrator indicated she would look into where the shower sheets were for the H, I, J, and K halls. During an interview, on 8/26/22 at 11:05 a.m., the Interim Administrator indicated staffing ratios should address care needs and acuity. A staffing review tool was used by the facility's managing corporation and would be offered for review. Review of a current facility document titled "Resident Rights..." dated 3/15/17 and provided by the Interim Administrator on 8/25/22 at 2:46 p.m., indicated the following: "...You have a right to a dignified existence, self-determination, and communication with and access to the persons and services inside and			

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	outside the facility...Receive the services and/or items included in the plan of care...You have the right to be treated with respect and dignity...The right to reside and receive services in the facility with reasonable accommodation of your needs and preferences...You have the right to make choices about the aspects of your life in the facility that are significant to you...You have a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely...." The shower sheets and staffing ratio tools were not provided by the facility prior to exit from the facility. Cross reference F550. Cross reference F838. Cross Reference F725. 3.1-38(a)(3) This Federal tag relates to Complaints IN00382938, IN00388110, and IN00388161.			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			

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	Based on observation, interview, and record review, the facility failed to identify and assess a skin impairment for 1 of 3 residents reviewed for skin conditions (Resident K). Findings include: During an interview, on 8/23/22 at 9:03 a.m., Resident K was in his room. His hair was greasy and his face was unshaved. He indicated he was supposed to receive a shower every Monday and Thursday. He had wanted his shower and a shave yesterday, which was a Monday, but he had been told the facility was too short-staffed, as there were three CNAs for the whole unit. The last time he had been shaved was the previous Thursday. He was incontinent, and would sit in urine for three to four hours at a time, as well as feces. He told staff around 15 minutes ago that he needed incontinence care and Social Services 44 had indicated she would leave his call light on so someone would come help him. He did not get his teeth brushed regularly. A family member had brushed his teeth the previous Saturday. He also had sores on his buttocks, although he had a cushion in his wheelchair. During an observation, on 8/23/22 at 9:23 a.m., the DON responded to the call light and indicated to the resident to "give us a few seconds". He indicated to her he had been incontinent of bowel and needed assistance. She told CNA 34 and the CNA indicated the resident was going to have to give them a few minutes. During an interview, on 8/23/22 at 9:36 a.m., CNA 34 indicated she had not yet gone to get anyone to help the resident with incontinent care, as she was still feeding residents and they were late getting trays.	F 0684	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ul="" role="list" Facility unable to identify resident K due to no identifier list providedA skin sweep was completed for all residents including resident K. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice A skin sweep was completed for all residents. All skin areas documented in skin event in medical record DNS/Designee will conduct an with all nursing staff skin management program/policy. Perineal care skills check off to be completed with all nursing staff. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? ul="" role="list" DNS/Designee will conduct an in-service with all nursing staff on Skin Management policy/program. Facility activity report to be reviewed by DNS/designee daily for new skin events to ensure documentation. Skin to be conducted monthly with nurse management team. Perineal care	09/28/2022

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	155106	A. BUILDING 00 B. WING	08/29/2022

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RIVERWALK VILLAGE	295 WESTFIELD RD NOBLESVILLE, IN 46060

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	Review of Resident K's clinical record was completed on 8/22/22 at 11:00 a.m. Diagnoses included, but were not limited to, Parkinson's disease, apraxia, right hand contracture, and lymphedema. He had current physician orders for, but not limited to, (6/9/22) hydrophilic wound dressing paste to gluteal fold twice daily for prevention, clean right hand with soap and water, pat dry, and place a rolled up wash cloth in right hand every shift, house moisture barrier cream to buttocks, groin, inner thighs, sacrum, and coccyx every shift, requires assist with ADLs, and transfer with mechanical lift and two staff. A 6/2/22, quarterly, MDS assessment indicated he was cognitively intact and required extensive assistance with ADLs and mobility. He was frequently incontinent of urine and always incontinent of bowel. His range of motion was impaired on one side. He had a current, 8/19/22, care plan problem of requires assistance with ADLs. Interventions included, but were not limited to, assist with bathing as needed per preference, offer showers twice weekly and a partial bath in between, and wash right hand and place rolled up washcloth in right hand. Review of a 8/18/22 weekly skin review indicated redness to his buttocks. Review of a 8/18/22 Braden risk assessment indicated he was at moderate risk for pressure injury. Review of a 8/25/22 weekly skin review indicated		skills check off to be completed with all nursing staff by DNS/designee. ul="" role="list" p paraid="135314969" paraeid="{7fc7b7f0-8e91-4079-9526-13a7673f3a30}{126}" >How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ul class="BulletListStyle1 SCXW146705939 BCX0" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

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	redness to his buttocks and no open areas. The clinical record did not include a wound assessment or measurements of a wound to his buttocks. During a wound care observation, on 8/25/22 at 11:34 a.m., accompanied by Unit Manager 39 and CNA 34, the Unit Manager indicated the resident did not receive a wound treatment, but only house skin cream. During the observation of the resident's buttocks, CNA 34 indicated the resident's brief was soiled with urine and would need changed. The wound observation indicated a superficially open red/pink wound with the surface area of skin gone to his inner left buttock. The Unit Manager confirmed it was approximately the size of a large pink eraser. She proceeded to apply a moderate amount of nourishing skin cream to his buttocks and groin area and a clean brief was applied. Neither staff member cleaned the resident's skin during the observation. During an interview, immediately following the care observation, Unit Manager 39 indicated she should have cleansed the resident's skin prior to applying the cream. The measurements and assessment of his wound should be in the wound management section of his clinical record. During an interview, on 8/29/22 at 9:31 a.m., the Float DON indicated wounds and skin impairments were to be documented as a skin event in the clinical record. This was to include measurement and provider notification. The DON or Unit Manager were responsible for following skin impairments. Review of a current facility policy titled "SKIN MANAGEMENT PROGRAM," dated 5/2022 and			

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	provided by the Interim Administrator on 8/29/22 at 9:43 a.m., indicated the following: "...Any skin alterations noted by direct care givers during daily care and/or shower days must be reported to the licensed nurse for further assessment, to include but not limited to, bruises, open areas, redness...The licensed nurse is responsible for assessing all skin alterations...Alterations in skin integrity will be reported to the MD/NP, the resident and/or resident representative as well as to the direct care staff...All newly identified areas after admission will be documented on the New Skin Event...A plan of care will be initiated to include resident specific risk factors and contributing factors with appropriate interventions implemented...." 3.1-37(a)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is			

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	demonstrably unavoidable. Based on observation, interview, and record review, the facility failed to ensure care of a contracture was completed for 1 of 2 residents reviewed for mobility (Resident K). Findings include: During an interview, on 8/23/22 at 9:03 a.m., Resident K was in his room. His hair was greasy and his face was unshaved. He indicated he was supposed to receive a shower every Monday and Thursday. He had wanted his shower and a shave yesterday, which was a Monday, but he had been told the facility was too short-staffed, as there were three CNAs for the whole unit. The last time he had been shaved was the previous Thursday. He had a splint for his right hand, which was on his refrigerator, but it had not been applied since the previous weekend. During an interview, on 8/24/22 at 10:03 a.m., the resident was seated in his wheelchair in his room. His right hand was in a flaccid fist. He indicated he had a splint in his room but it had not been applied since three days prior, nor did staff place a washcloth in his right hand. He was only able to use his left hand. Review of Resident K's clinical record was completed on 8/22/22 at 11:00 a.m. Diagnoses included, but were not limited to, Parkinson's disease, apraxia, right hand contracture, and lymphedema. He had current physician orders for, but not limited to, clean right hand with soap and water, pat dry, and place a rolled up wash cloth in right hand every shift, requires assist with ADLs, and transfer with mechanical lift and two staff.	F 0688	p paraid="564844992" paraeid="{7fc7b7f0-8e91-4079-9526-13a7673f3a30}{154}" >What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Facility unable to identify resident K due to no identifier list provided. ·All residents with splints reviewed by therapy services including resident K. p paraid="1621336912" paraeid="{5bdbae1b-b24a-4377-b2d8-0497d6b528e1}{29}" > How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents receiving splints have the potential to be affected by the alleged deficient practice ·Therapy to review all residents with splints. ul class="BulletListStyle1	09/28/2022

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	A 6/2/22, quarterly, MDS assessment indicated he was cognitively intact and required extensive assistance with ADLs and mobility. His range of motion was impaired on one side. He had a current, 8/19/22, care plan problem of requires assistance with ADLs. Interventions included, but were not limited to, assist with bathing as needed per preference, offer showers twice weekly and a partial bath in between, and wash right hand and place rolled up washcloth in right hand. During a confidential interview, a nursing department staff member indicated they were not sure if Resident K was supposed to have a splint of washcloth in his hand, but he could ask staff about it himself. Review of the resident's August Medication and Treatment Records indicated the nursing staff had signed off on completion of the placement of the washcloth. Review of a current facility Skills Validation for Splinting indicated the following: "...Apply splint according to therapy recommendations and/or aide assignment sheet...." 3.1-42(a)(2)		SCXW188993203 BCX0" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" DNS/Designee will conduct an in-service with all nursing staff on splint use and documentation. Splinting device application skills check to be completed with all nursing staff. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? Therapy to review all residents with splints. ·DNS/Designee will conduct an in-service with all nursing staff on splint use and documentation. ·Splinting device application skills check to be completed with all nursing staff. ·Splint to be included in resident profile and Resident Care sheets. ·DNS/designee will conduct an in-service with all nursing staff on	

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			daily review of Resident Care sheets. ·A daily rounding tool including splint use will be utilized by the Care Companions/Department Manager team. p paraid="524820290" paraeid="{7fc7b7f0-8e91-4079-9526-13a7673f3a30}{247}" > How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that			

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	resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on observation, interview, and record review, the facility failed to ensure urinary catheters were handled in accordance with professional standards for 1 of 2 residents reviewed for urinary catheters (Resident 59). Findings include:	F 0690	p paraid="1407885993" paraeid="{e2b1858f-73a7-40e5-8aeb-55cd8a497a3c}{28}" >What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	09/28/2022

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	On 8/24/22 at 8:55 a.m., Resident 59 was yelling for help from his bed. He indicated he felt "lousy" and couldn't find his call light. His urinary catheter drainage bag was hooked to the foot of the bed with urine and sediment backed up in the tubing. During an interview, on 8/24/22 at 9:05 a.m., QMA 36 indicated his urinary drainage bag should be below the level of his bladder. On 8/25/22 at 1:48 p.m., the resident was sitting up in his wheelchair with the call light on the floor behind the wheelchair. His catheter drainage tubing ran from his right pant leg to the drainage bag, with the tubing touching the floor. During an interview, following the observation, CNA 34 indicated the resident didn't get out of bed daily, so he was probably uncomfortable in the wheelchair. His tubing should absolutely not be on the floor, but it maybe had an inch before it touched. The resident's leg was higher on the foot pedal of the wheelchair during the interview with the CNA. On 8/25/22 at 3:22 p.m., he was in bed, with the frame low to the ground. His urinary drainage bag was hooked to the side of the bed, causing the tubing to coil on the floor. Resident 59's clinical record was reviewed on 8/23/22 at 12:18 p.m. Diagnoses included, but were not limited to, urinary tract infection (UTI), chronic systolic heart failure, Friedreich ataxia, dysphagia following TIA, and obstructive and reflux uropathy. A current, 8/19/22, care plan problem indicated he		Facility unable to identify resident 59 due to no identifier list provided. ·All residents with catheters including 59 reviewed by Nurse management team to ensure appropriate placement. ·All nursing staff re-educated by DNS/designee on Catheter storage. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents with foley catheters have the potential to be affected by the alleged deficient practice ul class="BulletListStyle1 SCXW17039780 BCX0" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" DNS/Designee will conduct an in-service with all nursing staff on	

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	had a UTI. He had a current care plan problem, reviewed 8/19/22, of urinary catheter use. Interventions included, but were not limited to, avoid obstructions in the drainage bag and position the bag below the bladder. During an interview, on 8/29/22 at 9:43 a.m., the Interim Administrator indicated the facility did not have a policy specific to catheter handling, only a skills check list. Review of a document titled "Caring for Your Foley Catheter," dated 3/20/19 and retrieved from www.my.clevelandclinic.org, indicated the following: "...The large bag can be hooked on the bed frame. Do not put it on the floor...Always keep the bag below the level of your bladder...."		Catheter storage. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? DNS/Designee will conduct an with all nursing staff on Catheter storage. ·All residents with catheters including 59 provided with catheter cover/bag. ·A daily rounding tool including catheter storage, placement, and cover/bag will be utilized by the Care Companions/Department Manager team. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ul class="BulletListStyle1 SCXW17039780 BCX0" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible;	

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			cursor: text; font-family: verdana;" POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.			

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	§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observations, record reviews and interviews, the facility failed to ensure staffing levels were adequate to ensure showers were provided, per care planned preferences, for 12 of 12 residents reviewed and observed for ADL's (Activities of Daily Living) (Resident's N, L, E, J, F, Q, D, C, M, K, G and R). Findings include: During a confidential interview, on 8/22/22, Confidential N indicated there were not enough staff to meet the needs of the residents. During a confidential interview, on 8/22/22, Confidential L indicated there were not enough staff to meet the needs of the residents, it had been that way for the past 5-6 months. During Resident Council meeting, on 8/23/22 at 11:49 a.m., a resident indicated they sometimes had to wait for an hour for their call light to be answered and would often have an incontinent episode while waiting. During Resident Council meeting, on 8/23/22 at 11:55 a.m., a family member indicated staffing had been an issue, there had been lack of responses to needs and lack of care when responses had occurred. During a confidential interview, on 8/24/22, Confidential H indicated there were not enough staff to meet the needs of the residents, she was doing all she could to try to get care needs	F 0725	Riverwalk Village respectfully requests additional evidentiary information be considered in eliminating or reducing Federal Tag 689. The current statement of deficiencies on the 2567 omits significant facility information and therefore misrepresents the care and services administered by the provider to its residents. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ul="" role="list" Facility wide staffing patterns reviewed and adjusted by ED, DNS, RDCS, RVP. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficiency ul="" role="list" Facility wide staffing patterns reviewed and adjusted by ED, DNS, RDCS, RVP. Increased internal and external agency usage to meet new staffing patterns. ED met with resident council to discuss changes in staffing	09/28/2022

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	completed. During a confidential interview, on 8/25/22, Confidential E indicated there were 30 residents that required two person assist, she washed up residents to the best of her ability, refusals of care are documented. The Unit Manager received shower sheets after shower was completed. During a confidential interview, on 8/25/22, Confidential J indicated she had worked 11 days straight, they had more residents that needed assistance than they used to have. Cross Reference F677, F550 and F883. 3.1-17(a) This Federal tag relates to Complaints IN00388110 and IN00388161.		patterns. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? Facility wide staffing patterns reviewed and adjusted by ED, DNS, RDCS, RVP. Staffing needs reviewed daily during Clinical Meeting Additional staffing needs sent to internal and external agencies as identified. HR meeting scheduled weekly to discuss open positions needed and job postings. All staff on new staffing patterns p="" paraid="1171780271" paraeid="{e2b1858f-73a7-40e5-8aeb-55cd8a497a3c}{250}"> How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name.			

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	(ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation, interview, and record review, the facility failed to ensure nursing staffing information was posted daily to reflect each tour of duty for 5 of 5 days of staffing information posting reviewed. Findings include:	F 0732	p paraid="99793960" paraeid="{9922d8a2-758b-4fcd-99a4-01ebd27f4a09}{31}" >What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	09/28/2022

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	The survey started on 8/22/22, as of 8/26/22 at 2:00 p.m., no daily nurse staffing information had been observed. During an interview, on 8/26/22 at 2:30 p.m., the interim Administrator indicated the DON usually posted staffing information at each hall but had not been at the facility during the survey week to post those. Review of a current facility policy, titled "Posted Nurse Staffing Data and Retention Requirements," dated 7/2019 and provided by the interim Administrator on 8/29/22 at 9:57 a.m., indicated "...Purpose of Policy: To allow public access to posted nursing staffing data per federal regulations...Procedure: 1. The facility must post the following information at the beginning of each shift. a. The facility name b. The current date c. Resident census d. The total number of actual worked hours by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: i. Registered nurses ii. Licensed practical nurses iii, Certified nurse aides...." Cross reference F838.		No residents were identified. ·Staffing numbers posted by ED/Designee. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ul class="BulletListStyle1 SCXW76709459 BCX0" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" ALL residents have the potential to be affected by the alleged deficient practice ED/Designee to post staffing daily. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? ED/Designee to post staffing daily.	

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			·Staffing reviewed during Clinical Meeting. ·Daily Rounding tool to include posted staffing completed by Care Companions/Department Manager daily. ·All Staff on required staffing posting and location p paraid="1593196912" paraeid="{9922d8a2-758b-4fcd-99a4-01ebd27f4a09}{130}" >How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

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F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure medications were securely stored for 2 random observations of medication storage (Rehabilitation Unit). Findings include: 1. During a random observation, on 8/24/22 at 12:51 p.m., an unlocked and unattended medication cart was outside of room 141. At 12:55 p.m., the Medical Records nurse went to get the	F 0761	p paraid="514933124" paraeid="{9922d8a2-758b-4fcd-99a4-01ebd27f4a09}{158}" >What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Medication carts were immediately and keys were	09/28/2022

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	nurse assigned to the cart, who was at the nurses station. LPN 47 indicated the cart should have been locked when not attended. An observation of the medication cart indicated the narcotic storage drawer was unlocked. LPN 47 indicated it should be kept locked when not in use. Resident P's hydrocodone 10-325 mg tablet count was 37 tablets, compared to 38 tablets noted in the narcotic count book. She indicated she had administered a dose and not signed it out. There was no signature on the narcotic shift count document. She confirmed she had not signed for acceptance of the cart and its contents nor completed a medication count prior to accepting the keys. 2. During a random observation, on 8/25/22 at 3:09 p.m., at Nurses Station 1 a medication cart was observed unlocked with keys hanging from the lock. No staff members were seen on the unit. During an interview at the time of the observation of her arrival on the unit at 8/25/22 at 3:13 p.m., Registered Nurse 73 indicated she was just coming onto the shift and had not left the keys in the medication cart. She took the keys and locked the cart. During an interview, on 8/25/22 at 3:14 p.m., the Floating Director of Nursing (DNS) indicated the medication cart should have been locked and the keys should not have been left in the cart lock. She indicated she was going to find out who left the keys and speak with him. During an interview, on 8/25/22 at 3:19 p.m., Qualified Medicine Aide (QMA) 74 indicated he had heard a resident yelling and had left the keys in the lock when he went to investigate. He indicated the medication cart contained the medications for the residents in rooms 148 - 159		secured. ¿ ·47 signed out administered medication and narcotic count was completed with no variance noted ·All licensed nurses and educated on medication storage policy ¿ How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ul class="BulletListStyle1 SCXW65647547 BCX0" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" All residents have the potential to be affected by the alleged deficient practice DNS/Designee will conduct an with all Licensed nurses and QMAs on medication storage policy	

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	including insulin. He indicated the narcotic lock box key was among the keys that were left in the medication cart lock. The narcotic box contained oxycodone, tramadol, and hydrocodone with acetaminophen. A current policy, revised 10/31/16, titled "Storage and Expiration of Medications, Biologicals, Syringes and Needles", and provided by the Interim Administrator on 8/29/22 at 9:43 a.m., indicated " ...Facility should ensure that only authorized Facility staff, as defined by Facility, should have possession of the keys, access cards, electronic codes, or combinations which open medication storage areas ...Facility should store Schedule ll Controlled Substances and other medications deemed by Facility to be at risk for abuse or diversion in a separate compartment within the locked medication carts and should have a different key or access device ...Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors ...Facility should ensure Schedule ll - V controlled substances are only accessible to licensed nursing, Pharmacy, and other medical personnel designated by Facility ..." 3.1-25(m)		What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? DNS/Designee will conduct an with all Licensed nurses and QMAs on medication storage policy ·Medication security to be checked daily using POC daily rounding tool How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ul class="BulletListStyle1 SCXW65647547 BCX0" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible;	

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			cursor: text; font-family: verdana;" If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
F 0838 SS=F Bldg. 00	483.70(e)(1)-(3) Facility Assessment §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided			

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	by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.			
	Based on record review and interview, the facility failed to comprehensively complete and implement a facility assessment to accurately determine the care and resources needed for resident care. Findings include: Review of the Facility Assessment, dated 2/25/22 and provided with Entrance Conference documents on 8/22/22, indicated it had been reviewed only by the former Administrator. There	F 0838	Riverwalk Village respectfully requests additional evidentiary information be considered in eliminating or reducing Federal Tag 689. The current statement of deficiencies on the 2567 omits significant facility information and therefore misrepresents the care and services administered by the provider to its residents.	09/28/2022

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	were an average of 85 residents on the long term care unit, 36 residents on the secured units, and 42 residents on the short-term/rehabilitation unit. The facility employed 35 CNAs at the time of the assessment. The assessment indicated there were mechanical lifts used in the facility and prompted an evaluation of staff in sufficient number to operate the lifts per policy. The assessment lacked documentation of evaluation of sufficient staffing for this task. There were 110 residents with incontinence and the form prompted evaluation of sufficient number of aides/nurses on each unit to adequately care for the residents. The assessment lacked documentation of evaluation of sufficient staffing for this task. The staffing pattern review section indicated full time positions for non-licensed nursing staff (aides) for each shift as follows: 20 for day shift, 21 for evenings, and seven for nights. The action plan section was left blank. Review of a current facility policy titled "Facility Assessment Policy," dated 1/2022 and provided with Entrance Conference documents on 8/22/22, indicated the following: "...The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for the residents competently during both day-to-day operations and emergencies...This assessment is used to make decisions about the direct care staff needs, as well as the capabilities to provide services to the residents in the facility...The facility assessment will be completed annually and reviewed during the monthly QAPI meetings as needed or with significant changes that would warrant review. The Executive Director will complete the Facility Assessment with input provided by all facility disciplines and departments...The Staffing Pattern Review section will be completed to ensure that the facility has an		p paraid="2020451632" paraeid="{bea24559-f2bb-4f9a-9719-65024b8de0df}{28}" >What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Facility assessment was reviewed by administrator and staffing adjusted. The Medical Director, Director of Nursing and current Administrator signed the review sheet for the facility assessment. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ul class="BulletListStyle1 SCXW219060774 BCX0" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" All residents have the potential to be affected by the alleged deficient practice Facility assessment was reviewed by administrator and reviewed by IDT at meeting.	

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	adequate number of competent staff to meet the needs of the residents. The review should include FTEs [full time employees] needed on each shift and each unit of the facility. The Action Area will be filled out if or when changes are made. During an interview, on 8/26/22 at 11:05 a.m., the Interim Administrator indicated staffing ratios should address care needs and acuity. A staffing review tool was used by the facility's managing corporation and would be offered for review. The Facility Assessment should be reviewed at least annually and updated with significant needs changes and should involve the QAPI team, not just the Administrator. Cross Reference F677. Cross Reference F725.		All staff re-educated on facility assessment completion and review p paraid="495063982" paraeid="{bea24559-f2bb-4f9a-9719-65024b8de0df}{83}" >What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? Facility assessment to be evaluated by IDT annually and with significant changes. ·The Administrator, DNS, and Medical Director will sign off on review at least annually. ·The facility assessment will be reviewed monthly during QAPI review. ·All staff re-educated on facility assessment completion and review How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?	

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			ul class="BulletListStyle1 SCXW219060774 BCX0" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, 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:			

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	§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; §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			

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	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 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 appropriate personal protective equipment (PPE) was used in resident rooms of those who required transmission-based precautions (TBP) to properly prevent and/or contain COVID-19 for 2 of 2 random observations (Resident 127 and Resident 91). Findings include: 1. During a random observation, on 8/25/22 at 8:47 a.m., CNA 46 was observed standing directly in front of Resident 127 while assisting her in the threshold of the bathroom. The CNA was wearing a surgical mask and gloves only. She left the room and entered the hallway, removing her gloves just before she opened the door to the dirty utility closet to discard the gloves. She then opened the clean linen storage closet and removed towels and washcloths. She removed another pair of gloves from the TBP supply cart outside of the resident's door. She did not perform hand hygiene or don additional PPE	F 0880	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; ul="" role="list" Isolation sign was moved for all residents on transmission-based precautions including residents 91 and 127 from the wall to the door. 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 potential to be affected by alleged deficient practice.An in-service will be completed by IP/designee for all staff to include proper infection control practices regarding donning and doffing personal protective equipment (PPE) for droplet plus isolation using Donning and Doffing of PPE in	09/28/2022

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	08/29/2022

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	before donning the gloves and entering the resident's room. During an interview, at the time of the observation, CNA 46 indicated she worked for a staffing agency and it was her first day at the facility. She did not realize the resident was in TBP and hadn't seen the yellow sign on the wall outside of her door. Resident 127's clinical record was reviewed on 8/25/22 at 9:30 a.m. Diagnoses included, but were not limited to, dementia and repeated falls. She had recieved the last of two doses of the COVID-19 vaccine in May 2021 and had not recieved any booster doses. 2. During a random observation, on 8/25/22 at 1:45 p.m., Housekeeper 49 was observed in Resident 91's room, mopping the floor at the side of the bed, where the resident was laying. The housekeeper was wearing a surgical mask and no additional PPE. There were discarded gowns and gloves on the floor near the door, next to the small trashcan. During an interview, on 8/25/22 at 1:53 p.m., Housekeeper 49 indicated he was new to the building and was not aware of needing any additional PPE when entering rooms requiring TBP. The facility was supposed to get him and another housekeeper trained and on-board with procedures as soon as they could. He had not noticed the yellow TBP signage on the wall outside of the resident's door. He was not aware of any additional housekeeping procedures needed for TBP rooms. Resident 91's clinical record was reviewed on 8/23/22 at 9:20 a.m. Diagnoses included, but were		Droplet Plus Isolation Skills Validation and Hand Hygiene Policy p="" paraid="737771149" paraeid="{bea24559-f2bb-4f9a-9719-65024b8de0df}{233}">What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; A Root Cause Analysis will be conducted with a consultant Infection Preventionist, with input from the facility Medical Director/IP/DNS to identify the root cause and develop solutions/systemic changes to address the root cause The will be reviewed with the consultant IP to determine accuracy An in-service will be completed by IP/designee for all staff to include proper infection control practices regarding donning and doffing personal protective equipment (PPE) for droplet plus isolation using Donning and Doffing of PPE in Droplet Plus Isolation Skills Validation and Hand Hygiene Policy IP will move isolation signs on all residents on precautions from wall to door Infection control practices included hand hygiene and the use of PPE to be reviewed daily utilizing POC daily rounding tool The consultant IP will provide ongoing training, oversight, and competencies as needed How the corrective action(s) will be monitored to ensure the deficient	

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	not limited to, malignant neoplasm upper lobe left lung, secondary malignant neoplasm of adrenal gland, and type 2 diabetes. She had declined any COVID-19 vaccinations. Review of a current facility policy titled "Standard and Transmission-Based Precautions (Isolation) Policy," dated February 2022 and provided by the Interim Adminsitrator on 8/25/22 at 2:46 p.m., indicated the following: "...DROPLET/CONTACT PRECAUTIONS...used to designate transmission-based precautions beyond droplet precautions associated with COVID-19, which includes the use of N-95 respirator...wear an N95 or higher-level respirator, eye protection...gloves, and gown when caring for these residents...." 3.1-18(l)		practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed The IP/DNS/Designee will monitor each solution/systemic change identified in the RCA daily or more often as necessary for and until compliance is maintained. POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. The facility will review, and make changes to the DPOC as needed with input and oversight from the Consultant Infection Preventionist for sustaining substantial compliance for no less than 6 months. After six months the will re-evaluate the continued need for the audit	