STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011274	A. BUILDING: _____ B. WING _____	C 11/07/2022

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RIVERWALK COMMUNITIES	401 S.E. 6TH STREET EVANSVILLE, IN 47713

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R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00390847 and IN00390879. This visit was in conjunction with a Post Survey Revisit (PSR) to Investigation of Complaint IN00371551 and Complaint IN00381248 completed on June 9, 2022. Complaint IN00390847- Substantiated. State deficiencies related to the allegations are cited at R0053. Complaint IN00390879- Unsubstantiated do to a lack of evidence. Unrelated deficiencies are cited. Survey date: November 2, 3, 7, 2022. Facility number: 011274 Residential Census: 97 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on November 17, 2022.	R 000		
R 053	410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency (w) Residents have the right to be free from verbal abuse. This RULE is not met as evidenced by: Based on interview and record review, the facility failed to ensure resident's were free from abuse. An employee verbally abused two of five	R 053		

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residents reviewed for abuse. (Resident B, Resident G)

Findings include:

1. On 11/2/22 at 10:54 a.m., Resident B's clinical record was reviewed. Resident B's diagnosis included, but not limited to, depression, headache, and history of cerebral vascular accident left sided. In a nursing note written on 8/31/2022 at 9:00 p.m." Resident was witnessed by other resident in facility that Certified Nurse Aide(CNA) was talking bad about resident. Spoke with CNA and stated that she was not talking about resident, and another CNA stated that she witnessed it to."

On 11/2/22 at 11:50 a.m., Resident B was interviewed about any concerns with abuse. She indicated that she had not been physically abused but had been verbally by a CNA. There was a CNA months ago that she indicated made fun of her and scolded her because she had soiled self. The CNA no longer worked here. Resident B indicated that she had treated her like an infant and taunted her because she had diarrhea. Resident indicated that she spoke with administration and there had been several other complaints about this CNA.

On 11/2/22 at 1:15 p.m., a State Reportable was reviewed and indicated that on 8/9/22 Resident B had soiled herself and CNA 1 had belittled her about soiling herself and the resident felt like she was treated like a child.

2. On 11/3/22 at 12:45 p.m., a State Reportable was reviewed and indicated on 8/9/22, Resident G had asked for help getting off the toilet and adjusting brief and pulling up pants. He indicated

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that CNA 1 pulled the briefs and pants up too quickly and he wanted to readjust the brief and pants. He also indicated that CNA 1 had gotten smart with the way she was talking to him and did not like the way the scene was turning out. Resident G felt threatened.

On 11/3/22 at 1:00 p.m., Resident G's clinical record was reviewed. Resident G's diagnosis included, but not limited to diabetes mellitus, CVA (Cerebral Vascular Accident), and paralysis. The nurse's notes lacked any concerns voiced by resident regarding the care or conflict with CNA 1.

On 11/3/22 at 1:15 p.m., Resident G was interviewed. Resident G indicated that CNA 1 came through the door she would ask him "what the hell he needed." Resident G indicated that he really does not remember the incident in August due to a stroke and has no short term memory.

On 11/3/22 at 2:12 p.m., An interview conducted with DON, Resident B indicated that CNA 1 had made comments about her soiling herself that she felt were degrading. There were no witnesses to this. The DON indicated that there was a second complaint on the same day against CNA 1 with Resident G. Resident G was upset that CNA 1 had cursed at him. There was an apparent witness to this altercation indicating that CNA 1 did not curse at him.
She indicated that the reportables were less than twenty four hours and that she substantiated both occurrences because they were on the same CNA. She indicated that there were written statements from Resident B and Resident G.

11/7/22 at 2:30 p.m., in an interview with the DON, she indicated that the social services person attempted to interview a few more

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R 053	Continued From page 3 residents and there was no documentation found. On 11/7/22 at 9:00 a.m, the DON provided a current undated policy for reporting abuse. The policy included but was not limited to, Our facility does not condone resident abuse by anyone including staff members...verbal abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance, too describe residents, regardless of their age, ability to comprehend, or disability. This State Residential Finding relates to Complaint IN00390847.	R 053		
R 297	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. This RULE is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure medications were given for 2 of 3 residents reviewed for medication administration. (Resident F, Resident G). Findings include: 1. On 11/3/22 at 1:11 p.m. clinical record was reviewed for Resident . Diagnoses included, but	R 297		

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was not limited to, motor vehicle accident with fracture left femur, and fracture left tibia. The resident was post operative for amputation of left great toe. The physician orders included but was not limited to,
amoxycillin-clavulanate(Augmentin) 875-125 (Antibiotic) dated 9/27/22 for 30 days x 60 doses, to be given by mouth every 12 hours starting 9/28/22 8:00 a.m. and ending 11/3/22 after 8:00 p.m. for diagnosis of amputation of L great toe.
Medication administration record (MAR) for November shows the Augmentin was administered on 11/1/22 at 8:00 a.m. and 8:00 p.m. and 11/2/22 at 8:00 p.m. No morning dose was documented on 11/2/22. Documentation on medication administration record (MAR) noted to stop Augmentin after 11/2/22 8:00 p.m.
The MAR for October had missed morning doses on Oct. 4, 5, 6, 12, 18, 22, 2, 26, 27, 31. Documentation on back of MAR reflects resident was away from the facility for all day on 10/2 and did not want medications so missed both doses and did not take medications on 10/16.
These were the only days documented. There was no documentation regarding Resident F having absences from the facility on the sign-out form or in the clinical record.

On 11/3/22 at 1:30 p.m., QMA 1 was interviewed, and indicated Resident F often fails to sign out when he leaves the facility.

On 11/7/22 10:01 a.m., Resident F indicated he had to wait a "couple of days" for one of his antibiotics to come in before he started taking it. Resident states he is done with the "big white horse pills" and doesn't remember the time and date of the last dose. Resident says he has no family that lives in Evansville and all the people he thought were his friends never come to see

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him, so he rarely goes off site.

2. On 11/2/22 at 11:19 a.m., Resident G's clinical record was reviewed. Resident G had diagnoses that included, but not limited to, Diabetes Mellitus, hypertension. A nursing progress note dated 10/27/22 at 8:30 a.m., indicated that Resident G had a new order for Levaquin (antibiotic) 500 mg (milligram) for 10 days. A progress note dated 10/28/22 at 4:00 p.m., indicated Resident G was receiving an antibiotic for a urinary tract infection.

A physicians order dated 10/28/22 was reviewed and indicated Levaquin 500 mg by mouth every day for 10 days.

On 11/2/22 at 11:30 a.m., the November and October MAR (Medication Administration Record), was reviewed. The November MAR did not contain Resident G's antibiotic order. A medication card for Levaquin 500 mg was observed to be in the medication cart. The card had 9 spots for medication, 7 doses were missing, 2 doses remained.

The October 2022 MAR was reviewed. An order dated 10/28/22 for Levaquin 500 mg 1 by mouth every day for 10 days was observed written on the MAR. 12 noon was written for the time to administer, a line with an arrow at the end was drawn to the date of 10/27/22. The medication was signed out as given on 10/29/22, 10/30/22, 10/31/22, 10/27/22 & 10/28/22 were blank.

On 11/7/22 at 11:00 a.m., a nursing progress note dated 11/3/22 at 8:55 a.m., indicated a call was placed to Resident G's physician to inform him of the missed doses of Levaquin, Resident G no longer presents with urinary tract symptoms, order noted to discontinue the Levaquin.

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R 297	Continued From page 6 On 11/2/22 at 11:44 a.m., QMA 2 indicated Resident G's antibiotic order was not on the November MAR, she was unsure why, but Resident G was receiving an antibiotic for a urinary tract infection. She indicated the ADON does the monthly rewrites, and it should have been transferred to the November MAR. QMA 2 indicated Resident G did not receive her antibiotic on 11/1/22 because she slept most of the day and refused to get up and take it. QMA 2 was unsure why 7 doses of the medication were missing and only 3 days were signed out on the October MAR. On 11/3/22 at 9:10 a.m., the DON indicated LPN 1 got the first dose of the antibiotic out of the emergency drug kit and administered it to Resident G on 10/27/22, that is why the pharmacy only sent 9 doses instead of 10. The DON indicated she had notified Resident G's physician of the discrepancy of the antibiotic, she thought the QMA's had administered the antibiotic without signing the MAR, and was unsure why 7 does were missing and only 3 had been signed out on the MAR. On 11/3/22 at 11:59 a.m. the DON indicated the ADON (Assistant Director of Nursing), was in charge of the monthly rewrites for orders, but RN 1 did the order rewrite for Resident G on 10/27/22, the nursing staff are responsible to ensure medication orders are transferred to the next month. On 11/3/22 at 8:46 a.m., Resident G indicated she is unsure if she receives her medications as ordered. On 11/7/22 at 8:44 a.m., the DON provided the current Medication Administration Policy	R 297		

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R 297	Continued From page 7 Statement, with one revision, dated 10/25/19. The policy included, but is not limited to: all medication is to be administered as prescribed; the nurse administering the medication is to initial the resident's medication record in the space provided under the date for that drug and the scheduled time of administration; if a regularly-scheduled drug is withheld or refused the nurse is to initial and circle the initial in the resident's medication record; if the medication is out of stock, the pharmacy contracted to deliver the medication as soon as possible, the physician will be notified if the resident consistently refuses medications/treatment or if the medication is out of stock and cannot be delivered in a timely manner.	R 297		