STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155106	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverwalk Village	295 Westfield Rd Noblesville, IN 46060

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview, and record review, the facility failed to ensure residents were free from chemical restraints regarding the use of antipsychotic medication without gradual dose reductions and/or documented behavioral indicators for use for 2 of 4 residents reviewed for the use of antipsychotic medications (Resident 19 and 13). Findings include: 1. Resident 19's clinical record was reviewed on 1/15/26 at 10:25 a.m. Current diagnoses included dementia severe with agitation, anxiety and bipolar disorder.The resident had a current physician's order for the following antipsychotic medication: Risperdal 1mg- give 1 tablet two (2) times daily. This order originated 11/25/24 (1 year and 2 months).A 12/22/25, quarterly, Minimum Date Set (MDS) assessment indicated the resident was moderately cognitively impaired, did not have either hallucinations or delusions during the assessment period, did not display maladaptive behaviors during the assessment period, and received antipsychotic and antidepressant medications.The resident's clinical record contained documentation of three behavioral events during the past three-and-a-half-month period (October 1, 2025, to January 16, 2026). The behavioral events did not contain documentation of hallucinations (see, hearing or feeling things that aren't present), delusions (fixed false beliefs), or psychotic behaviors (loss of contact with reality). The documented events occurred on 10/2/25, 10/6/25 and 11/4/25 and involved yelling, name calling, exit seeking, and refusing or resisting care.A 12/1/25, Pharmacy Recommendation indicated the following recommended dose reduction: . receives Risperidone 1 mg twice a day for expressions of distress related to dementia (e.g. dementia with psychosis). Recommendation: Please attempt a gradual dose reduction (GDR) of Risperidone to 0.5 mg in the morning and 1 mg in the afternoon. Rational for Recommendations: CMS [Center for Medicare/Medicaid Services] requires that antipsychotics, being used to treat expressions or indications of distress related to dementia, be evaluated at least quarterly with documentation regarding continued clinical appropriateness.GDR is attempted in 2 separate quarters, with at least 1 month between attempts.The medical provider declined the dose reduction and documented the following reply: Was placed on it while inpatient psych. Currently doing well on unit. Guardian has refused med changes. The form did not contain a statement of contraindication which included a risk benefit analysis (the evaluation of potential negative outcomes against the potential positive benefits to make an informed determination to determine if advantages outweigh the potential for harm.) The clinical record lacked documentation of any education to the guardian regarding the restrictions associated with the right to decline care and treatment and the requirement that medication be medically necessary at its current dosage to treat a current medical symptom or condition.A 1/16/26, Psychiatry Progress Note, indicated the resident received the antipsychotic medication Risperidone one tablet two times a day. The medication was started on 11/25/24 and was used to treat dementia. She displayed no hallucinations or delusions. The resident was tearful and stated she had been down in the dumps. She had periods of agitation due to behavioral and psychological symptoms of dementia. Her symptom of agitation was listed as (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intermittent exit seeking. The resident was negative for signs of anxiety, psychotic symptoms, or suicidal ideations. During an observation on 1/16/26 at 10:20 a.m., Resident 19 was resting on her bed. There was a person seated in a chair beside her. She was conversing with the visitor.During an observation on 1/20/26 at 12:51 p.m. the resident was seated on her bed in her room. She indicated she had eaten a good lunch. 2. Resident 13's clinical record was reviewed on 1/15/26 at 2:42 p.m. Current diagnoses included dementia with behavioral disturbances, schizoaffective disorder, depression and anxiety.The resident had a current physician's order for the following antipsychotic medication(s): Zyprexa 2.5 mg daily in the morning. This order originated 2/11/25 (11 months prior).Zyprexa 7.5 mg daily at bedtime. This order originated 2/11/25. A 1/7/26, quarterly MDS assessment indicated the resident was moderately cognitively impaired, did not have either hallucinations or delusions during the assessment period, did not display maladaptive behaviors during the assessment period, and received antipsychotic, antianxiety, antidepressant, and hypnotic medications.The resident's clinical record contained documentation of two behavioral events during the past three-and-a-half-month period (October 1, 2025, to January 16, 2026). The behavioral events did not contain documentation of hallucinations, delusions, or psychotic behaviors. The documented events occurred on 10/6/25 and 10/20/25 and involved refusing medication, yelling out, and cursing.A 1/7/26, Pharmacy Recommendation indicated the following recommended dose reduction: received an antipsychotic, Olanzapine (Zyprexa) 2.5 mg a day and 7.5 mg in the evening for Schizoaffective disorder since January 2025. Please consider a gradual dose reduction to 2.5 mg once a day and 5 mg in the evening. Rationale for Recommendation: CMS requires that antipsychotics, used to treat an enduring condition other than dementia, be evaluated at least quarterly with documentation regarding continues clinical appropriateness.The medical provider declined the dose reduction and documented the following: Resident has continued to have periods of delusions & increasing Namenda (dementia medication) dose today. The form did not contain a statement of contraindication which included a risk benefit. The clinical record lacked any documentation of delusions during the period of 10/1/25 to 1/16/26. A, 1/16/26, Psychiatry Progress Note, indicated: The resident received the antipsychotic medication Zyprexa 2.5 mg in the morning and 7.5 mg at bedtime for persecutorial delusions which become distressful to the resident. The resident had no hallucinations and was believed to have persecutorial delusions. The medication Zyprexa had not had a GDR and was contraindicated for reduction on 5/2/25, 8/8/25, 9/5/25, and 1/9/26.During an observation on 1/14/2026 at10:50 a.m., Resident 13 was participating in a group activity. She was calm, smiling and participating.During an observation on 1/16/26 at 10:19 a.m., the resident was resting on her bed. She was awake and calm. During an observation on 1/20/26 at 12:51 p.m., the resident was seated on the side of her bed in her room. She was calm. During an interview on 1/20/26 at 12:47 p.m., the Dementia Unit Director indicated Resident 13 did not display maladaptive behaviors and she had never witnessed her display signs of delusions or hallucinations. Resident 19 wandered some, but did not display behaviors that negatively impacted her quality of life or quality of care. Resident 19 did have a past history of assault and at times appeared to believe that event was current or just happened.During an interview on 1/20/26 at 12:53 p.m., C.N.A. 13 indicated Resident 13 called down the hall at times and forgot she had received her medications. Resident 13 did not appear to have delusions or hallucinations. Resident 19 did not display negative behaviors and did not appear to have delusions or hallucinations.During an interview on 1/20/26 at 12:57 p.m., LPN 12 indicated Resident 13 sometimes yelled down the hallway wanting her medication or forgetting she had her medication. She did not display symptoms of hallucinations or delusions. Resident 19 sometimes displayed exit seeking behaviors and went to the backdoor to go outside and smoke. The resident did not display (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	symptoms or hallucinations.During an interview on 1/20/26 at 1:01 p.m., C.N.A. 11 indicated Resident 13 often spoke loudly or called out down the hallway, but she didn't display negative behaviors nor appear to have hallucinations or delusions. Resident 19 did not display negative behaviors and did not appear to have delusions or hallucinations.During an interview on 1/20/26 at 1:29 p.m., the Social Services Director, Social Services Assistant, and Dementia Unit Director each indicated the facility did not have statements of contraindication for GDRs of antipsychotic medications for Residents 13 and 19 which included a risk benefit analysis. The facility did not have any additional documentation of hallucinations, delusions, psychosis or maladaptive behaviors displayed by Residents 13 and 19 from October 1, 2025, until present. Maladaptive behaviors were to be documented in the resident's clinical record. Review of a current 7/2025, facility policy titled Psychotropic Management, provided by the Administrator via email on 1/20/26 at 12:42 p.m., indicated the following: .Gradual dose reductions (GDR) and the use of non-pharmacological interventions will occur for residents receiving psychotropic medication unless contraindicated by the prescriber with specific rationale why the reduction was not indicated.5. For antipsychotic medications, diagnoses alone do not necessarily warrant the use the medications (sic). Antipsychotic medication may be indicated if:a. behavior symptoms present a danger to the resident or others;b. expressions or indications of distress that are significant distress to the resident;.c. GDR was attempted but symptoms returned. 3.1-3(w)3.1-26(k)(1)(o)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interview, the facility failed to implement immediate fall interventions and/or follow fall interventions to prevent further falls for a dependent resident at high risk for falls for 1 of 5 residents reviewed for accidents. (Resident 112)Finding includes:During an observation on 1/14/26 at 2:03 p.m., Resident 112 was seated in her wheelchair at the table in the dining room and being assisted with her meal. Resident 112's clinical record was reviewed on 1/14/26 at 3:16 p.m. Diagnoses included Alzheimer's Disease, atrial fibrillation, abnormal posture, unsteadiness on feet, and other abnormalities of gait and mobility. Current orders included metoprolol tartrate (blood pressure/heart rate) 25 mg every 12 hours (8/26/25).A 10/17/25, annual, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired. A wheelchair was used for mobility. The resident was dependent on staff assistance for eating toileting, bathing, dressing, footwear, and personal hygiene. She required substantial staff assistance to stand and transfer. Resident 112 had one fall with injury since the prior assessment. A current care plan, dated 6/3/22, indicated the resident was at risk for falls due to advanced age, incontinence, high risk medication use, impaired cognition, impaired mobility, Alzheimer's disease, dementia, anxiety, hypertension, unsteadiness on feet, and abnormalities of gait and mobility. Interventions included the following: Assist the resident to the recliner or bed after meals (6/6/22), the resident is a high fall risk (6/30/23), transfer the resident to a standard chair for all meals (7/11/25), therapy screening for the resident (10/22/25), labs to rule out an acute illness (10/27/25), and therapy screening for the resident (12/15/25). Review of the resident's fall risk assessments for July 2025 and October 2025 indicated the resident was at high risk for falls.Resident 112's fall events, immediate interventions, and progress notes indicated the following:On 7/11/25 at 7:26 a.m., the resident had an unwitnessed fall from her wheelchair in the dining room. The fall resulted in pain and an abrasion to the head. Continued resident care was the immediate intervention. On 7/11/25 at 10:44 a.m., the Interdisciplinary Team (IDT) note indicated the resident had a fall on 7/11/25 at 7:26 a.m. after she was wheeled to the dining room for breakfast. Ice was applied to the abrasion to the scalp, and the resident was assisted to bed for an immediate intervention. An intervention for the resident to be transferred to a standard chair for all meals was put into place to address the root cause of the fall. On 10/20/25 at 2:15 p.m., the resident had an unwitnessed fall with no injuries from her wheelchair in the dining room. The resident was placed in bed after her meal for the immediate intervention. On 10/21/25 at 10:44 a.m., the Interdisciplinary Team (IDT) note indicated the resident had a fall on 10/20/25 at 2:15 p.m. when the resident was found in the floor in the dining room. The resident was assessed and assisted back into the wheelchair for an immediate intervention.On 10/25/25 at 10:50 a.m., the clinical record lacked a fall event note with all the details of the resident's fall and immediate intervention.On 10/25/25 at 11:28 a.m., the resident had an unwitnessed fall with no injuries from her wheelchair in the dining room after she finished breakfast. The resident was placed in bed for the immediate intervention. On 10/25/25 at 11:35 a.m., a progress note indicated Resident 112 had two unwitnessed falls within the same time. The falls on 10/25/25 occurred at 10:50 a.m. and 11:20 a.m. (Details of each fall were not included.) On 10/27/25 at 10:15 a.m., the Interdisciplinary Team (IDT) note indicated the resident had two falls on 10/25/25. One occurred at 10:50 a.m. and another one at 11:20 a.m. Both falls were similar in the way they occurred. The resident was assisted back into the wheelchair for a small activity as an immediate intervention for the first fall. The resident was assisted to bed as an immediate intervention for the second fall that day.On 10/27/25 at 8:27 p.m., a progress note indicated a urinalysis was collected from the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/14/25 at 6:26 a.m., the resident had a witnessed fall, near the nurse's station, when the resident leaned forward and slipped out of the wheelchair. A contributing factor was the resident's wheelchair pad was placed upside down by the night shift aide. The resident was sent to the emergency room for as an immediate intervention. On 12/14/25 at 10:30 a.m., a progress note indicated the resident had a witnessed fall early that morning with no sign of injury at the time of the fall. Upon reassessment, after 20 minutes, the resident was lethargic, sleepy, and had bruising to the top of the forehead. The provider was notified of the change in condition, and an order was obtained to send the resident to the Emergency Room.On 12/15/25 at 10:06 a.m., the IDT note indicated the resident had a fall from the wheelchair on 12/14/25 at 6:26 a.m. The resident was assessed and assisted back into the wheelchair as an immediate intervention. During an observation on 1/16/26 at 1:01 p.m., QMA 7 assisted Resident 112 down the hallway in her wheelchair from her room to the dining room. QMA 7 positioned the resident at the end of the dining room table in her wheelchair and locked the wheels. Resident 112 was not placed into a standard chair (according to her fall interventions). QMA 7 left the dining room and returned to the J Hall to assist other residents to the dining room. No staff were present in the dining room supervising until 1/16/26 at 1:10 p.m. A male staff member entered the dining room, but Resident 112 remained in the wheelchair. On 1/16/26 at 1:25 p.m., Resident 112's meal tray was delivered. The resident remained in her wheelchair and was assisted by a staff member with her meal. Interviews indicated the following:On 1/16/26 at 1:34 p.m., LPN 4 indicated Resident 112 was seated at the dining room table in her wheelchair while she was assisted with her meal. The resident was at high risk for falls due to cognitive impairment, a history of falls, non-verbal communication, and unsteadiness on her feet. The resident's fall intervention for a standard chair was not being followed. Failure to follow the resident's fall interventions placed the resident at risk for further falls. On 1/20/26 at 1:04 p.m., CNA 8 indicated Resident 112 had the following fall interventions: the resident required a gait belt for transfers, the resident was to be transferred to a standard chair in the dining room for all meals and required to be checked in bed and changed. On 1/20/26 at 1:38 p.m., RN 6 indicated nurses were required to complete a fall event to include an assessment of the resident with each fall. With each fall, the nurse must initiate a resident specific intervention to prevent further falls. The aides were aware of the fall interventions by report between shifts and by referencing the CNA care sheets.On 1/20/26 at 2:01 p.m., Unit Manager 9 indicated Resident 112 had a fall intervention on the CNA care sheet to be transferred to a standard chair for meals. The fall interventions on the CNA care sheets should have been followed. Failure to follow the fall interventions placed the resident at risk for further falls. The CNA care sheets were always available to the CNAs and were updated daily. Each fall required a new fall event, assessments, and surrounding events even when the falls occur on the same day. Unit Manager 9 could not provide two separate events for Resident 112's falls that occurred on 10/25/25. On 1/20/26 at 2:22 p.m., the DON indicated residents should have separate fall events for each fall to include immediate interventions to prevent further falls at the time of the fall. Failure to follow fall interventions placed the residents at risk for further falls. On 1/20/26 at 3:18 p.m., the Administrator indicated, on 1/16/26, the CNA care sheets lacked Resident 112's fall intervention to be placed in a standard chair at mealtimes. It had not pulled forward on the CNA care sheets from the resident's care plan. The CNAs were not aware of the intervention.A current facility policy, last revised 8/2022, titled Fall Management Policy, provided by the Administrator on 1/20/26 at 12:24 p.m., indicated the following: POLICY: It is the policy. to ensure residents residing within the facility receive adequate supervision and or assistance to prevent injury related to falls. Facilities must implement comprehensive, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident-centered fall prevention plans for each resident at risk for falls or with a history of falls.3.1-45(a)(2)