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	04/04/2024

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 40241 Based on observation, interview, and record review, the facility failed to complete verification of the correct type of insulin prior to administration for 1 of 3 residents reviewed for insulin use, resulting in the wrong type of insulin being given. (Resident B) Findings include: Resident B's clinical record was reviewed on 4/4/24 at 9:43 a.m. Diagnoses included type 2 diabetes mellitus without complications. His physicians orders included glargine-yfgn insulin (long-acting insulin) pen 40 units subcutaneously daily in the a.m. (started on 3/11/24) and Levemir (long- acting insulin) 55 units subcutaneously at bedtime (started on 2/20/24 - discontinued on 3/19/24). A 2/9/24 significant change Minimum Data Set (MDS) assessment indicated he was cognitively intact. His blood sugars on 3/16/24 were 180 mg/dL at 8:00 p.m., 184 mg/dL at 8:13 p.m., 150 mg/dL at 8:20 p.m., and 167 mg/dL at 8:33 p.m. A nurses note, dated 3/16/24 at 8:45 p.m. (recorded as a late entry on 3/17/24 at 3:09 p.m.), indicated a medication error was made. He received 55 units of Novolog insulin (short acting insulin) instead of 55 units of Levemir insulin. An accucheck was performed and read 180 mg/dL directly afterwards. He was brought to the nurses station for monitoring. The on-call physician was notified immediately and requested to have him sent to the emergency room (ER). His accuchecks were done frequently until the EMTs arrived. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Riverwalk Village		STREET ADDRESS, CITY, STATE, ZIP CODE 295 Westfield Rd Noblesville, IN 46060	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An ER note, dated 3/16/24 at 8:58 p.m., indicated he was transferred to the hospital after a medication error. He was treated with 55 units of subcutaneous Novolog insulin rather than 55 units of Levemir insulin. His blood sugar was 150 mg/dL during transport to the hospital with EMS and 180 mg/dL upon arrival to the ER. He denied feeling like he had low blood sugar, and he was encouraged to eat and drink a soft drink. He was started on 5 % dextrose (solution used to provide your body with extra water and carbohydrates (calories from sugar)), however, his blood sugar continued to drop as low as 66 mg/dL and he was started on 10% dextrose. He had improvement and stability of his blood sugar (around 170's) in the ER. He was also given supplemental potassium for hypokalemia (low blood potassium), likely caused by the insulin. With the resolution of his hypoglycemia (low blood sugar), it was decided that it was safe for him to return to the facility from the ER. He resumed his regular insulin and staff should take caution with which insulin they gave him. A nurses note, dated 3/17/24 at 3:28 a.m., indicated the hospital was called to check his status. He had been admitted to have his blood sugars monitored. A nurses note, dated 3/17/24 at 11:17 a.m., indicated he was admitted to the hospital but there was no bed available, and he remained in the ER. He had dextrose running via IV. If his blood sugar remained within normal limits in the next couple of hours, he would be discharged back to the facility. A nurses note, dated 3/17/24 at 11:24 p.m., indicated he was at the facility, and he had an IV in his left arm. During an interview with RN 14, on 4/4/24 at 11:20 a.m., she indicated it had been her first time working on that medication cart. She went to give Resident B his insulin in his belly. She didn't look at the pen to verify it was his, or the right insulin, prior to administering it to him. As she administered the insulin, she realized the pen was orange (Novolog) rather than green (Levemir). She immediately stopped administering the insulin, went to the computer to look up the insulins and got the other two nurses that were working. They got him up in his wheelchair and rechecked his blood sugar. She thought his blood sugar was 150 mg/dL or 180 mg/dL. They called the on-call physician and they didn't answer, so they called the endocrinologist, who told them to just continue to monitor him. The on-call physician called back and told them to send him to the ER. He was transported to the ER and he stayed stable. The facility provided her education related to the medication error. During an interview with RN 14, on 4/4/24 at 1:00 p.m., she indicated she had grabbed the resident's storage bag containing his insulin from the medication cart. His name was on the storage bag, but someone must have put someone else's insulin pen in his bag. She wasn't sure whose insulin pen she used. During an interview with Resident B, on 4/4/24 at 1:02 p.m., he indicated he was sent to the hospital because a nurse gave him an immediate release insulin when he was supposed to get a long-acting insulin, but she caught it right away. They got him up, put him in his wheelchair and took him to the nurses station. They took his blood sugar, and kept checking on him. (continued on next page)

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Riverwalk Village	295 Westfield Rd Noblesville, IN 46060

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current facility policy, revised on 1/1/22, tilted General Dose Preparation and Medication Administration, provided by the DON on 4/4/24 at 1:18 p.m., indicated the following: .Procedure .3.7 Facility staff should verify that the medication name and dose are correct when compared to the medication order on the medication administration record .4.1 Facility staff should: 4.1.1 Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident, as set forth in facility's medication administration schedule 3.1-48(c)(2) This citation relates to Complaint IN00430621.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 40241 Based on observation, interview, and record review, the facility failed to date resident's insulin vials and insulin flex pens after opening in accordance with facility policy (Resident G, C, D, E, F, and H) for 2 of 3 medication carts observed. (H hall and K/I medication carts) During a medication administration observation, on 4/4/24 at 11:55 a.m., with RN 14, she administered 22 units of Lispro (short acting insulin) insulin to Resident G. Neither the insulin vial, nor the container, had an open date on it. RN 14 checked other in-use insulins stored in the H hall medication cart and the following in-use insulins lacked open dates: 1. Resident C's Lispro insulin vial. 2. Resident D's Lispro insulin vial and a glargine-yfgn (long acting insulin) insulin pen with 180 of 300 units used from the pen. 3. Resident E's insulin aspart (short acting insulin) insulin pen with 280 units of 300 units used from the pen. 4. Resident F's glargine-fygn insulin pen with 280 units of 300 units used from the pen. RN 12 indicated they would normally date the insulin vials and pens after opening. During an observation of the K/I hall medication cart, accompanied by LPN 23, on 4/4/24 at 12:45 p.m., Resident H's in-use insulin glargine pen had no open date on it, 160 units of insulin had been used from the 300 unit pen. LPN 23 indicated she would normally date the insulin as soon as she pulled it from the refrigerator. A current facility policy, revised on 1/1/22, tilted General Dose Preparation and Medication Administration, provided by the DON on 4/4/24 at 1:18 p.m., indicated the following: .Procedure .3.12 Facility staff should enter the date opened on the label of medications with shortened expiration dates (e.g., insulins .) 3.1-25(j) This citation relates to Complaint IN00430621.