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	11/27/2024

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 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. 48146 Based on record review and interview, the facility failed to accurately assess for fall risks, to implement fall interventions, and to thoroughly document falls for 1 of 3 residents reviewed for falls with injury. (Resident F) Findings include: Resident F's clinical record was reviewed on 11/26/24 at 4:00 p.m. Diagnoses included unspecified dementia, difficulty walking, and history of falling. A 8/29/24, Geriatric Interim Care Note from Resident F's admission paperwork indicated the following: fall one week ago on 8/21/24, with right hip pain ongoing. The fall one week ago was out of a chair onto right hip, did not hit head, able to get up unassisted. Hip was painful without improvement. He still walked and bore his own weight. Dementia with behavioral disturbances, likely mixed vascular and Alzheimer's Disease. He had been getting more assistance with ADLs and iADLs, which family had been providing. Skilled nursing placement required for wound care. A 9/3/24, Admission Fall Assessment document indicated the resident had no falls in the previous six months, was incontinent of bowel and bladder, no tethering equipment, no mobility issues, and had an altered awareness of his surroundings. The fall assessment score was 9, which indicated a moderate fall risk. A new admission care plan, dated 9/3/24, indicated implementation of services to include assistance with activities of daily living. The approaches included the following: Assist with transfers, ambulation, bed mobility, toileting and/or incontinent care, eating/drinking, and bathing/hygiene, including oral/dental care. Provide fall prevention interventions: (call light in reach, area free of clutter, room orientation, non-skid footwear when out of bed, other). A progress note, dated 9/3/24 at 5:00 p.m., indicated the resident arrived with family, ambulated with a walker, was continent of bowel and bladder, and was seen with walker, peering under the bed. Resident F was shown the call light and told to alert staff if something was needed. Resident F was very unsteady on feet and left walker outside of bathroom and would not allow staff to help him. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A late entry progress note, dated 9/3/24 at 6:45 p.m., initiated on 9/4/24 at 4:56 p.m., indicated the resident was found on the floor, in the doorway, seated upright with legs extended. Resident F was previously seen in bed. Resident was assessed for injury, assisted to stand, and given his walker. He indicated he fell . A late entry progress note, dated 9/3/24 at 7:16 p.m., initiated on 9/4/24 at 4:57 p.m., indicated the Director of Nursing (DON) and family were notified of fall and a new order to send the resident to the emergency room for assessment. A progress note, dated 9/3/24 at 7:59 p.m., indicated the resident was found lying on the floor, on his left side. There was a large amount of blood and an open area to his head that was larger than when he arrived. Resident F was assessed and assisted into a chair. Resident F was alert and answered questions. Pressure was held to the wound. Physician was notified and an order to send to the emergency room was given. A 9/4/24, Interdisciplinary Team (IDT) Fall note indicated the resident was a new admit and was observed ambulating with a walker. He had an unsteady gait prior to the fall. He was observed lying on his left side in street clothing and non skid shoes. He stated he was unsure what he was attempting to do. Staff earlier reported him attempting to look under furniture. Resident F received a laceration to the head. Resident F was sent to the emergency room for evaluation and treatment. He was admitted to the hospital. Root cause found to be new admission with confusion to immediate surroundings and unsteady gait. Care plan was updated. A 9/3/24 Fall Event, initiated on 9/4/24 at 4:47 p.m., indicated the resident had an unwitnessed fall without injury. The resident was previously seen lying in bed. The immediate intervention was to assess the resident and assist back to standing position. A 9/3/24 Fall Event, initiated on 9/3/24 at 7:59 p.m., indicated the resident had an unwitnessed fall with head pain and a laceration. The resident was up with walker in room. The immediate intervention was to send the resident to the emergency room for evaluation. A progress note dated 9/4/24 at 7:48 a.m., indicated the resident was admitted to the hospital with the diagnosis of a brain bleed. During an interview, on 11/26/24 at 12:23 p.m., RN 7 indicated when a resident fell , the staff needed to immediately assess the resident and the environment before moving them. The electronic medical record had a fall event staff were to complete with as much information as possible. This included vitals signs, the circumstances of the fall, and the new interventions immediately used after the fall. Fall interventions should be specific to each resident and the needs of the resident. The DON and physician should be called immediately. During an interview, on 11/27/24 at 11:14 a.m., the ADON indicated when a new resident admitted to the facility, the nursing staff received an intake referral form and general hospital or physician paperwork. The staff were able to access and review this information about a resident's condition and diagnosis. She was not on staff when Resident F admitted . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 11/27/24 at 11:29 a.m., the DON indicated the nurses on staff reported falls to her. At the time of this report, the DON and staff member reviewed the current fall interventions and immediately added new interventions to prevent further falls. The fall interventions were reviewed in the next IDT meeting to ensure they were appropriate or if they should be changed. The DON indicated the staff member working the night Resident F admitted and had two falls did not follow the policies and procedures of the facility. A current facility policy, revised 8/22, titled, Fall Management Policy, provided by the Administrator on 11/27/24 at 12:51 p.m., indicated the following: . 1. Fall risk/fall prevention will be assessed upon admission . 2. All new admission will be considered a fall risk based upon his/her new living arrangements and his/her reasons for being admitted into the nursing facility. 3. A care plan will be developed at the time of admission with specific care plan interventions to address each resident's fall risk factors . 5. Residents who are categorized as moderate to high risk should have fall interventions based on resident specific risk factors . Post Fall . A fall event will be initiated as soon as the resident has been assessed and cared for. The report must be completed in full in order to identify possible root causes of the fall and provide immediate interventions This citation relates to Complaint IN00448034. 3.1-45 (a)(2)