

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 10/30/2024
NAME OF PROVIDER OR SUPPLIER Riverwalk Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42685</p> <p>Based on record review and interview, the facility failed to ensure shift-to-shift narcotic count and reconciliation was completed for 6 of 7 medication carts reviewed for medication reconciliation. (Carts HI, [NAME], [NAME], C, D, and Cottage 2)</p> <p>Findings include:</p> <p>1. During a medication storage observation of the HI medication cart, on 10/25/24 at 11:27 a.m., accompanied by LPN 7, the Narcotic Count Sheet was reviewed and the following dates lacked shift-to-shift count and reconciliation signatures of controlled medications:</p> <p>October 2024- lacked a narcotic card count:</p> <p>1st, 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, 9th, 10th, 11th, and 12th.</p> <p>October 2024- lacked shift-to-shift narcotic reconciliation signatures:</p> <p>10/2: 6:00 a.m. - 2:00 p.m., 10/5: 6:00 a.m. - 2:00 p.m. and 2:00 p.m. - 10:00 p.m., 10/6: 6:00 a.m. - 2:00 p.m., 10/9: 6:00 a.m. - 2:00 p.m. and 2:00 p.m. - 10:00 p.m., 10/10: 6:00 a.m. - 2:00 p.m., 10/12: 6:00 a.m. - 2:00 p.m. and 10:00 p.m. - 6:00 a.m. 10/25: 6:00 a.m. - 2:00 p.m.</p> <p>(continued on next page)</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview, at the time of observation, LPN 7 indicated no one had signed the narcotic count for the HI cart for days shift on 10/25/24. She had been late that day and LPN 6 completed the shift to shift narcotic count with the night shift nurse prior to her arrival. She had completed a shift to shift narcotic count with LPN 6 upon her arrival but neither of them had completed the reconciliation when the HI cart was transferred from one employee to the next. The shift to shift narcotic counts and signatures were required each time the medication cart was transferred from one employee to the next.</p> <p>2. During a medication storage observation of the [NAME] medication cart, on 10/25/24 at 10:12 a.m., accompanied by LPN 8, the Narcotic Count Sheet was reviewed and the following dates lacked shift-to-shift count and reconciliation signatures of controlled medications:</p> <p>October 2024- lacked a narcotic card count:</p> <p>1st, 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, 9th, 10th, 21st, 22nd, 23rd, and 24th.</p> <p>October 2024- lacked shift-to-shift narcotic reconciliation signatures:</p> <p>10/1: 10:00 p.m. - 6:00 a.m.- 2:00 p.m.,</p> <p>10/7: 2:00 p.m. - 10:00 p.m.,</p> <p>10/8: 2:00 p.m. - 10:00 p.m.,</p> <p>10/9: 6:00 a.m. - 2:00 p.m.</p> <p>3. During a medication storage observation of the [NAME] medication cart, on 10/25/24 at 11:42 a.m., accompanied by LPN 6, the Narcotic Count Sheet was reviewed and the following dates lacked shift-to-shift count and reconciliation signatures of controlled medications:</p> <p>October 2024- lacked a narcotic card count:</p> <p>1st, 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, 9th, 10th, 22nd, and 23rd.</p> <p>October 2024- lacked shift-to-shift narcotic reconciliation signatures:</p> <p>10/1: 2:00 p.m.- 10:00 p.m. and 10:00 p.m. - 6:00 a.m.,</p> <p>10/2: 2:00 p.m. - 10:00 p.m.,</p> <p>10/4: 2:00 p.m. - 10:00 p.m.,</p> <p>10/5: 6:00 a.m. - 2:00 p.m., 2:00 p.m. - 10:00 p.m.,</p> <p>10/6: 6:00 a.m. - 2:00 p.m., 2:00 p.m. - 10:00 p.m., and 10:00 p.m. - 6:00 a.m.,</p> <p>10/9: 2:00 p.m. - 10:00 p.m.,</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>10/10: 6:00 a.m. - 2:00 p.m., 2:00 p.m.- 10:00 p.m., 10:00 p.m. - 6:00 a.m.</p> <p>During an interview, at the time of observation, LPN 6 indicated the narcotic count sheet should have been completed by both staff members when the medication cart was transferred from one staff member to another. A count should have included the number of controlled medication cards and bottles with each transfer of the medication carts.</p> <p>48146</p> <p>4. During a medication storage observation of the D hall medication cart, on 10/25/24 at 12:15 p.m., accompanied by RN 3, the Narcotic Count Sheet sheet was reviewed and the following dates lacked shift to shift count and reconciliation signatures of controlled medications:</p> <p>October 2024- lacked a narcotic card count</p> <p>1st, 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, 9th, 11th, 12th, 13th,14th, 15th, 19th, 20th, 21st, 22nd, and 23rd.</p> <p>October 2024- lacked shift-to-shift narcotic reconciliation signatures</p> <p>10/1: 6:00 a.m. - 2:00 p.m., 2:00 p.m. - 10:00 p.m., 10:00 p.m. - 6:00 a.m.,</p> <p>10/2: 6:00 a.m. - 2:00 p.m. and 10:00 p.m. - 6:00 a.m.,</p> <p>10/4: 6:00 a.m. - 2:00 p.m. and 2:00 p.m. - 10:00 p.m.,</p> <p>10/9: 2:00 p.m. - 10:00 p.m.,</p> <p>10/17: 10:00 p.m. - 6:00 a.m.,</p> <p>10/21: 6:00 a.m. - 2:00 p.m.,</p> <p>10/23: 6:00 a.m. - 2:00 p.m.</p> <p>5. During a medication storage observation of the C hall medication cart, on 10/25/24 at 12:15 p.m., accompanied by RN 3, the Narcotic Count Sheet sheet was reviewed and the following dates lacked shift to shift count and reconciliation signatures of controlled medications:</p> <p>October 2024- lacked a narcotic card count</p> <p>1st, 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, 9th, 11th, 12th, 13th, 14th, 15th, 16th, 19th, 20th, 21st, 22nd, and 23rd.</p> <p>October 2024- lacked shift-to-shift narcotic reconciliation signatures</p> <p>10/1: 2:00 p.m. - 10:00 p.m. and 10:00 p.m. - 6:00 a.m.,</p> <p>10/2: 10:00 p.m. - 6:00 a.m.,</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>10/6: 6:00 a.m. - 2:00 p.m. and 2:00 p.m. - 10:00 p.m.,</p> <p>10/7: 2:00 p.m.- 10:00 p.m. and 10:00 p.m. - 6:00 a.m.,</p> <p>10/8: 2:00 p.m. - 10:00 p.m. and 10:00 p.m. - 6:00 a.m.,</p> <p>10/9: 10:00 p.m. - 6:00 a.m.</p> <p>During an interview, at the time of the observations, RN 3 indicated her assignment included using both carts to administer medication. The sign in/sign out sheet was to be completed by nurses at the beginning and ending of their shifts.</p> <p>6. During a medication storage observation of the Cottage 2 medication cart, on 10/25/24 at 12:24 p.m., accompanied by LPN 4, the Narcotic Count Sheet sheet was reviewed and the following dates lacked shift to shift count and reconciliation signatures of controlled medications:</p> <p>October 2024- lacked a narcotic card count</p> <p>1st, 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, 9th, 10th, 11th, 13th, 16th, 17th, 18th, and 20th.</p> <p>October 2024- lacked shift-to-shift narcotic reconciliation signatures</p> <p>10/2: 2:00 p.m. - 10:00 p.m.,</p> <p>10/3: 2:00 p.m. - 10:00 p.m. and 10:00 p.m. - 6:00 a.m.,</p> <p>10/4: 10:00 p.m. - 6:00 a.m.,</p> <p>10/5: 6:00 a.m. - 2:00 p.m., 2:00 p.m. - 10:00 p.m., and 10:00 p.m. - 6:00 a.m.,</p> <p>10/7: 10:00 p.m. - 6:00 a.m.,</p> <p>10/10: 6:00 a.m. - 2:00 p.m. and 2:00 p.m. - 10:00 p.m.,</p> <p>10/11: 6:00 a.m. - 2:00 p.m., 2:00 p.m. - 10:00 p.m., and 10:00 p.m. - 6:00 a.m.,</p> <p>10/12: 6:00 a.m. - 2:00 p.m. and 2:00 p.m. - 10:00 p.m.,</p> <p>10/24: 2:00 p.m.- 10:00 p.m.</p> <p>During an interview, at the time of the observations, LPN 4 indicated the sign in/sign out sheet was completed at the beginning and end of each shift to verify the narcotic count was correct.</p> <p>During an interview, on 10/25/24 at 1:43 p.m., the DON indicated she discovered the facility was utilizing the wrong sign in/sign out forms and changed them on October 10th. The expectation for staff was for the sheet to be filled out completely. The oncoming nurse and offgoing nurse count narcotics and sign the count sheets at the beginning and end of every shift to help prevent drug diversion.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A current facility policy, revised 8/1/24, titled, Inventory Control of Controlled Substances, provided by the DON on 10/28/24 at 1:49 p.m., indicated the following: . Facility should ensure that the incoming and outgoing nurse count all Schedule II controlled substances and other medications with a risk of abuse or diversion at the change of each shift or at least once daily and document the results on a Controlled Substance Count Verification/Shift Count Sheet. Facility should: Reconcile the total number of controlled medications on hand, add newly received medications to the inventory, and removed medications that are completed or discontinued from the inventory .</p> <p>3.1- 25(b)(3)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48146</p> <p>Based on observation and interview, the facility failed to appropriately discard expired insulin pens and label medications with resident information in 2 of 6 medication carts observed for medication storage. (D and Cottage 2)</p> <p>Findings include:</p> <p>1. During a medication storage observation of the D hall medication cart, accompanied by RN 3, on [DATE] at 12:15 p.m., the following was observed:</p> <p>One unlabeled 8 milligram (mg) ondansetron (to prevent vomiting) blister packaged pill.</p> <p>One glargine (insulin) pen, with approximately 25 units remaining, with an open date of [DATE].</p> <p>During an interview, at the time of the observation, RN 3 indicated the ondansetron pill must have fallen out of the bag and the insulin was expired and should not be given to the resident.</p> <p>2. During a medication storage observation of the Cottage 2 medication cart, accompanied by LPN 4, on [DATE] at 12:24 p.m., the following was observed:</p> <p>One unlabeled bottle of morphine (a narcotic pain reliever) with approximately 14 units remaining.</p> <p>During an interview, at the time of the observation, LPN 4 indicated the bottle had been removed from the facility's medication management system and should have been labeled with resident information.</p> <p>A current facility policy, revised [DATE], titled, Storage and Expiration Dating of Medications and Biologicals, provided by the Administrator on [DATE] at 10:46 a.m., indicated the following: .11. Once a medication or biological package is opened, facility should follow manufacture/supplier guidelines with respect to expiration dates for opened medications .12. Facility should destroy and reorder medications and biologicals with soiled, illegible,worn, makeshift, incomplete, damaged, or missing labels .</p> <p>A current facility document, dated 2022, titled, Dating Medications & Supplies, provided by the Administrator on [DATE] at 11:50 a.m., indicated the following: .Discard expired/undated medications and supplies .</p> <p>3XXX,d+[DATE] (j)</p> <p>3XXX,d+[DATE] (k)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>42685</p> <p>Based on observation, interview, and record review, the facility failed to implement enhanced barrier precautions (EBP) during high contact care for 3 of 6 residents reviewed for infection control. (Residents 41, 2, and 79)</p> <p>Findings include:</p> <p>1. During an observation on 10/23/24 at 11:16 a.m., there was no indication of EBP outside of Resident 41's room.</p> <p>A Resident Matrix document, provided by the facility on 10/23/24, indicated Resident 41 had a Stage III (full-thickness skin loss, exposing fat tissue but not muscle, tendon, or bone) pressure ulcer.</p> <p>During an observation on 10/24/24 at 4:29 p.m., the resident was in bed on a low air loss mattress. There was no indication of EBP outside or inside the resident's room.</p> <p>Resident 41's clinical record was reviewed on 10/25/24 at 10:22 a.m. Diagnoses included, dementia, anorexia, unspecified severe protein-calorie malnutrition, and abnormal posture.</p> <p>A current physician order, dated 10/10/24, included Santyl (wound treatment) ointment 250 units per gram - cleanse open area to the sacrum with normal saline and apply Santyl to the wound bed and cover with a foam dressing. The clinical record lacked indication of enhanced barrier precautions.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 9/27/24, indicated the resident was cognitively impaired. She was dependent on staff assistance for toileting, dressing, transfers, and personal hygiene. The resident had an unhealed pressure ulcer.</p> <p>The clinical record lacked a care plan for enhanced barrier precautions.</p> <p>During a wound care observation on 10/25/24 from 10:24 a.m. to 10:40 a.m. , upon entry to the room, there was no indication of EBP inside or outside the room. LPN 6 and the ADON performed hand hygiene and donned gloves prior to the wound treatment. Gowns were not readily available for use inside the room. Both staff members walked over to the resident's right side of her bed, which was against the wall, leaned in against the resident's bed linens with their exposed clothing, and assisted the resident onto her left side for wound care on her right buttock near the sacrum. The old dressing was removed from the open right buttock wound, with scant serous drainage noted. Following wound care, LPN 6 and the ADON provided perineal care as they leaned in against the resident's bed linens with their exposed clothing. Gowns were not worn by either staff member during the course of the observation.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/29/24 at 11:59 a.m., CNA 11 indicated staff were required to wear a gown and gloves for high contact care activities when a resident was in enhanced barrier precautions. She was made aware when a resident was in enhanced barrier precautions by the enhanced barrier precaution signs hung outside the residents' doors. Specific precautions were also listed on the CNA assignment sheets. She indicated she was providing care for Resident 41 on this date and had not followed enhanced barrier precautions for her high contact care because the resident was not in enhanced barrier precautions. She had only worn gloves. The resident had a chronic wound, but had not been placed in enhanced barrier precautions. She knew residents with catheters required enhanced barrier precautions, but she was uncertain what other reasons a resident may need enhanced barrier precautions.</p> <p>Review of the provided CNA assignment sheet, at the time of the interview, lacked indication of enhanced barrier precautions.</p> <p>During an interview on 10/29/24 at 12:15 p.m., LPN 6 indicated residents with enhanced barrier precautions had a sign outside their room, above their bed, and an order in their chart for enhanced barrier precautions. Enhanced barrier precautions were required for residents with catheters, open wounds, and ostomies. Resident 41 should have had enhanced barrier precautions implemented by the Infection Preventionist, but it was not implemented. Since the sign was not present, she and the ADON had not followed enhanced barrier precautions during the resident's wound care observation and perineal care on 10/25/24. She should have known to follow enhanced barrier precautions, even though signs were not posted, since the resident had an open wound. A gown and gloves were required during the resident's high-contact care.</p> <p>During an interview on 10/29/24 at 12:31 p.m., the ADON indicated enhanced barrier precautions should have been previously initiated when the resident's open wound was identified.</p> <p>48146</p> <p>2. Resident 2's clinical record was reviewed on 10/25/24 at 9:30 a.m. Diagnosis included spastic quadriplegic cerebral palsy, unspecified severe protein-calorie malnutrition, oropharyngeal dysphagia, and epilepsy.</p> <p>A physician's order, dated 5/17/24, indicated may crush appropriate medications and administer per gastrostomy tube. Check placement of gastrostomy tube and check residuals (fluid or contents in the stomach).</p> <p>A physician's order, dated 6/4/24, indicated enteral feeding (to provide nutrition), gastrostomy tube, size 18 French (diameter of the tube).</p> <p>An isolation care plan, dated 6/10/24, indicated the resident was at risk of transferring Multidrug-Resistant Organisms (MDROs) and required enhanced barrier precautions related to indwelling medical devices. The approaches included to use standard precautions including hand hygiene and to wear gown and gloves for high-contact resident care activities.</p> <p>During an observation, on 10/23/24 at 9:50 a.m., Resident 2's room had an Enhanced Barrier Precautions sign on the wall directly beside the door. Personal protective equipment (PPE) was in a plastic container directly below the sign. Resident 2 was lying in bed with an enteral tube pump at bedside.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a medication administration observation, on 10/25/24 at 8:21 a.m., RN 3 crushed medications for Resident 2. RN 3 donned gloves and lifted the resident's gown to access the gastrostomy tube to her left abdomen and completed the medication administration.</p> <p>During an interview, on 10/25/24 at 8:51 a.m., RN 3 indicated Resident 2 was in enhanced barrier precautions and she had forgotten to don a gown while providing care to her gastrostomy tube. The enhanced barrier precaution required staff to wear protection when working with resident that have catheters, gastrostomy tubes and wounds or openings in the skin to prevent the spread of infection.</p> <p>3. Resident 79's clinical record was reviewed on 10/28/24 at 10:08 a.m. Diagnosis included malignant neoplasm of the prostate, type 2 diabetes mellitus, benign prostatic hyperplasia, and a stage 3 (full thickness tissue loss) pressure ulcer to left heel.</p> <p>A physician's order, dated 10/22/24, indicated cleanse left heel wound with Dakin's (an antiseptic) solution, apply Hydrofera Blue (to treat bacteria and protect) to wound bed every 3 days on day shift and as needed.</p> <p>An isolation care plan, dated 4/17/24, indicated Resident 79 was at risk of transferring MDRO's and required enhanced barrier precautions related chronic wounds requiring a dressing. The approaches included to use standard precautions including hand hygiene and to wear gown and gloves for high contact resident care activities.</p> <p>During a wound care observation, on 10/28/24 at 9:47 a.m., Resident 79 was lying in bed. An enhanced barrier precautions sign was taped to the wall at the foot of his bed. His bed was against the wall horizontally. Two nursing staff members performed hand hygiene and donned gloves. The Unit Manager set up a sterile field on the bedside table. LPN 6 was assisting by holding the residents left leg up at the ankle. The Unit Manager removed the bandage to the resident's left leg. The open wound was approximately the size of a quarter. The Unit Manager performed wound care while LPN 6 held the resident's leg. The Unit Manager gathered the used supplies and trash to dispose of and performed hand hygiene.</p> <p>During an interview, at the time of the observation, LPN 6 and the Unit Manager both indicated Resident 79 was on enhanced barrier precautions for his open wound and they had both forgotten to don a gown prior to beginning his wound care treatment. LPN 6 indicated enhanced barrier precautions were to be worn when working with residents that have catheters, feeding tubes, and open wounds.</p> <p>During an interview, on 10/30/24 at 1:51 p.m., the DON indicated it was the expectation for staff to follow all the guideline for enhanced barrier precautions. These precautions assist in preventing the spread of infections. The residents who required enhanced barrier precautions had catheters, feeding tubes, MDRO's, and open wounds requiring a dressing.</p> <p>During an interview, on 10/30/24 at 2:25 p.m., the Infection Preventionist indicated staff were expected to understand the enhanced barrier precautions protocols. She placed signs and PPE at the residents' rooms that required enhanced barrier precautions. All staff should have worn PPE when providing care for an open wound or giving medications through a gastrostomy tube.</p> <p>(continued on next page)</p>		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A current facility policy, revised 4/24/24, titled, Standard Precautions and Transmission- Based Precautions (Isolation) Policy, provided by the DON on 10/28/24 at 1:49 p.m., indicated the following: .Enhanced Barrier Precautions (EBP): An intervention designed to reduce the transmission of resistant organisms that employs targeted use of gown and glove use during high contact resident care activities. EBP expands the use of PPE beyond situations in which exposure to blood and body fluids is anticipated, it refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Enhanced barrier precautions are used for: Resident(s) with chronic wounds and/or indwelling medical devices, regardless of their MDRO status .Wounds generally include .pressure ulcers . Indwelling medical device examples include .feeding tubes .</p> <p>3.1-18(l)</p>		