

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 010885	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/21/2014
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NAME OF PROVIDER OR SUPPLIER RIVERBEND	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 CHARLESTOWN PIKE JEFFERSONVILLE, IN 47130
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00158133.</p> <p>Complaint IN00158133 - Unsubstantiated due to lack of evidence.</p> <p>Survey Date: October 21, 2014</p> <p>Facility Number: 010885 Provider Number: N/A AIM Number: NA</p> <p>Survey Team: Gloria J. Reisert, MSW, TC</p> <p>Census bed type: Residential: 109 Total: 109</p> <p>Census payor type: Other: 109 Total: 109</p> <p>Sample: 03</p> <p>Riverbend was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00158133.</p> <p>Quality Review 10/22/14 by Lisa McColly</p>	R 000		

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