STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	2715 CHARLESTOWN PIKE, JEFFERSONVILLE, , 47130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intakes IN00461463 and IN00463372. Intake IN00461463 - No deficiencies related to the allegation is cited. Intake IN00463372 - State deficiency related to the allegations is cited at R0052. Survey date: August 18, 2025 Facility number: 010885 Residential Census: 88 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on August 20, 2025.	R 0000		
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be	R 0052	R 052 1. Resident D’s leave of absence (LOA) is being	09/01/2025

free from:

(1) sexual abuse;

(2) physical abuse;

(3) mental abuse;

(4) corporal punishment;

(5) neglect; and

(6) involuntary seclusion.

Based on interview and record review, the facility failed to ensure staff were aware of a resident (Resident D) who readmitted on night shift for over 12 hours for 1 of 3 residents reviewed for neglect.

Findings include:

The clinical record for Resident D was reviewed on 8/18/25 at 10:33 a.m. The resident's diagnoses included, but were not limited to, dementia, diabetes, anxiety, hypothyroidism and constipation.

The incident report, dated 7/12/25 at 5:46 p.m., indicated Resident D returned from the hospital on 7/12/25 at 2:22 a.m. During shift change, it was reported to day shift that the resident had returned. The day shift nursing staff did not realize the resident had returned from the hospital until the resident fell. The fall detection system alerted the day shift nursing

monitored to ensure the Community is aware of resident’s status.

2. The Community reviewed each resident’s record to determine which residents, if any, could be affected by the alleged deficient practice.

3. The Wellness Director reviewed 24-hour reports for all LOAs and the last 30 days to ensure proper documentation was completed on all returned residents. The Wellness director in-serviced all nursing staff on leave of absence procedures, including the specific notifications required upon readmission. 4. The Wellness director or designee will audit 24-hour reports five days a week for all residents on LOA for the next 6 months.

5. Systemic Change: September 1, 2025

team members at 5:37 p.m. on 7/12/25. The resident did not receive her 8:00 a.m. medications or blood sugar checks prior 5:37 p.m.

The progress note, dated 7/10/25 at 10:57 p.m., indicated the resident was admitted to the hospital after a fall at the facility.

The progress note, dated 7/12/25 at 2:20 a.m., indicated the resident returned from the hospital, she was transferred to her bed and was sleeping soundly.

The resident's service plan/care summary, dated 8/4/25, indicated the resident was non-ambulatory and required the following assistance:

- maxiumum full assistance with dressing in the morning

- maximum full assistance with personal hygiene

- maximum full assistance with toileting with incontinence checks during waking hours

- required extensive hand-on assistance with mobility

- required assistance with cutting up food and opening cartons for meals

- safety checks every 2 hours

The July 2025 medication

	administration record indicated the resident was to receive the following medications: - Buspirone (antianxiety medication) 10 mg (milligrams) twice daily at 8 a.m. and 8:00 p.m. - Cinnamon (used to assist with healthy blood sugar levels) 500 mg twice daily at 8:00 a.m. and 8:00 p.m. - Divalproex (antianxiety medication) 250 mg twice daily at 8:00 a.m. and 8:00 p.m. - Insulin Glargine (long acting insulin for diabetes) 8 units subcutaneously at 8:00 a.m. - Jardiance (diabetes medication) 25 mg daily at 8:00 a.m. - Memantine (dementia medication) 10 gm twice daily at 8:00 a.m. and 8:00 p.m. - Blood sugar checks before meals at 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. - Senoxon (medication for constipation) 8.6 mg, 2 tablets at 8:00 a.m.			

The July 2025 medication administration record indicated the resident did not receive any of the above medications, on 7/12/25 at 8:00 a.m., due to the resident was out of the facility.

The progress note, dated 7/12/25 at 5:45 p.m., indicated the staff were alerted that the resident was on the floor, lying on her back. The resident reported that her back and shoulders were hurt. The family requested the resident be sent to the hospital for evaluation.

During an interview, on 8/18/25 at 1:13 p.m., Qualified Medication Aide (QMA) 2 indicated the facility needed someone to work from 6:00 a.m. until 8:00 a.m. on the assisted living locked memory care; and scheduled her for the open spot on day shift on 7/12/25 from 6:00 a.m. until 8:00 a.m. Licensed Practical Nurse (LPN) gave her report, but did not mention anything about Resident D. She asked Certified Nursing Aide (CNA) 3 if they were going to get Resident D up for breakfast and CNA 3 reported to her that the resident was still in the hospital.

During a telephone interview, on 8/18/25 at 1:16 p.m., CNA 3 indicated on 7/12/25 she did not get to work that morning until 6:10 a.m. By the time she had gotten to work, the night shift

aides had left and she did not get report from any of the other day shift staff. She worked until 6:00 p.m. that day. The staff were unaware that the resident had returned. The staff heard her screaming and went in her room and found her on the floor. She was wet, but not soaked. She had not been changed all day until she was found on the floor. The resident did not receive any fluids, her breakfast, or have any lunch because the staff were unaware she was back. She was provided something from the kitchen after they found her on 7/12/25 after 5:37 p.m.

During an interview, on 8/18/25 at 2:23 p.m., the Wellness Director indicated they had put multiple preventive things in place after the event.

On 8/18/25 at 9:39 a.m., the Executive Director provided a current copy of the document titled "Abuse Prevention Policy" dated 8/10/18. It included, but was not limited to, "Purpose...To establish guidelines and procedures for preventing, investigations, reporting and resolving allegations of...neglect...Policy...It is the policy of the Facility to protect residents...Neglect...The failure to provide goods and services necessary to avoid physical harm, mental anguish...Abuse Prevention Standards...The

	Facility enforces and protects all recognized rights of its Residents...Residents have the right to be free from...neglect...." This State Citation relates to Intake IN00463372. Based on interview and record review, the facility failed to ensure staff were aware of a resident (Resident D) who readmitted on night shift for over 12 hours for 1 of 3 residents reviewed for neglect. Findings include: The clinical record for Resident D was reviewed on 8/18/25 at 10:33 a.m. The resident's diagnoses included, but were not limited to, dementia, diabetes, anxiety, hypothyroidism and constipation.			

The incident report, dated 7/12/25 at 5:46 p.m., indicated Resident D returned from the hospital on 7/12/25 at 2:22 a.m. During shift change, it was reported to day shift that the resident had returned. The day shift nursing staff did not realize the resident had returned from the hospital until the resident fell. The fall detection system alerted the day shift nursing team members at 5:37 p.m. on 7/12/25. The resident did not receive her 8:00 a.m. medications or blood sugar checks prior 5:37 p.m.

The progress note, dated 7/10/25 at 10:57 p.m., indicated the resident was admitted to the hospital after a fall at the facility.

The progress note, dated 7/12/25 at 2:20 a.m., indicated the resident returned from the hospital, she was transferred to her bed and was sleeping soundly.

The resident's service plan/care summary, dated 8/4/25, indicated the resident was non-ambulatory and required the following assistance:

- maxiumum full assistance with dressing in the morning

- maximum full assistance with personal hygiene

- maximum full assistance with toileting with incontinence

checks during waking hours

- required extensive hand-on assistance with mobility

- required assistance with cutting up food and opening cartons for meals

- safety checks every 2 hours

The July 2025 medication administration record indicated the resident was to receive the following medications:

- Buspirone (antianxiety medication) 10 mg (milligrams) twice daily at 8 a.m. and 8:00 p.m.

- Cinnamon (used to assist with healthy blood sugar levels) 500 mg twice daily at 8:00 a.m. and 8:00 p.m.

- Divalproex (antianxiety medication) 250 mg twice daily at 8:00 a.m. and 8:00 p.m.

- Insulin Glargine (long acting insulin for diabetes) 8 units subcutaneously at 8:00 a.m.

- Jardiance (diabetes medication) 25 mg daily at 8:00 a.m.

- Memantine (dementia medication) 10 gm twice daily at 8:00 a.m. and 8:00 p.m.

- Blood sugar checks before meals at 8:00 a.m., 12:00 p.m.,

4:00 p.m. and 8:00 p.m.

- Senoxon (medication for constipation) 8.6 mg, 2 tablets at 8:00 a.m.

The July 2025 medication administration record indicated the resident did not receive any of the above medications, on 7/12/25 at 8:00 a.m., due to the resident was out of the facility.

The progress note, dated 7/12/25 at 5:45 p.m., indicated the staff were alerted that the resident was on the floor, lying on her back. The resident reported that her back and shoulders were hurt. The family requested the resident be sent to the hospital for evaluation.

During an interview, on 8/18/25 at 1:13 p.m., Qualified Medication Aide (QMA) 2 indicated the facility needed someone to work from 6:00 a.m. until 8:00 a.m. on the assisted living locked memory care; and scheduled her for the open spot on day shift on 7/12/25 from 6:00 a.m. until 8:00 a.m. Licensed Practical Nurse (LPN) gave her report, but did not mention anything about Resident D. She asked Certified Nursing Aide (CNA) 3 if they were going to get Resident D up for breakfast and CNA 3 reported to her that the resident was still in the hospital.

During a telephone interview, on

8/18/25 at 1:16 p.m., CNA 3 indicated on 7/12/25 she did not get to work that morning until 6:10 a.m. By the time she had gotten to work, the night shift aides had left and she did not get report from any of the other day shift staff. She worked until 6:00 p.m. that day. The staff were unaware that the resident had returned. The staff heard her screaming and went in her room and found her on the floor. She was wet, but not soaked. She had not been changed all day until she was found on the floor. The resident did not receive any fluids, her breakfast, or have any lunch because the staff were unaware she was back. She was provided something from the kitchen after they found her on 7/12/25 after 5:37 p.m.

During an interview, on 8/18/25 at 2:23 p.m., the Wellness Director indicated they had put multiple preventive things in place after the event.

On 8/18/25 at 9:39 a.m., the Executive Director provided a current copy of the document titled "Abuse Prevention Policy" dated 8/10/18. It included, but was not limited to, "Purpose...To establish guidelines and procedures for preventing, investigations, reporting and resolving allegations of...neglect...Policy...It is the policy of the Facility to protect

	residents...Neglect...The failure to provide goods and services necessary to avoid physical harm, mental anguish...Abuse Prevention Standards...The Facility enforces and protects all recognized rights of its Residents...Residents have the right to be free from...neglect...." This State Citation relates to Intake IN00463372.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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