STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/11/2025

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 Complaint IN00460885. Complaint IN00460885 - State deficiencies related to the allegations are cited at R0243 and R0297. Survey dates: June 10 and 11, 2025 Facility number: 010885 Residential Census: 80 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 13, 2025.	R 0000		
R 0243	Health Services - Deficiency 410 IAC 16.2-5-4(e)(3) (3) The individual administering the medication shall document the administration in the individual ' s	R 0243	1 The Community reviewed Resident E’s active medication orders to confirm that Resident E’s medication administration record	06/27/2025

	medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on interview and record review, the facility failed to ensure a resident's (Resident E) medication administration record reflected the Health Services for 1 of 3 residents reviewed for medication administration. Findings include: The clinical record for Resident E was reviewed on 6/10/25 at 4:22 p.m. The resident's diagnoses included, but were not limited to, insomnia, depression and dementia. The physician's order, dated 5/20/25, indicated the resident was to receive Trazodone (medication for insomnia) 50 mg (milligrams) at 8:00 p.m. The June 2025 medication administration record lacked documentation of the administration of the resident's Trazodone on 6/8/25 at 8:00 p.m.		(MAR) is correct. Resident E is now receiving all prescribed medication. The Community informed Resident E's physician regarding the missed medication doses. 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 (WD) will in-service all QMAs and Nurses on "Common Medication Errors" by 6/27/25 to educate and ensure that the deficient practice does not recur. 4 To ensure the deficient practices do not recur the WD or designee is to audit the Missed Medications noted under Missed Medications Tab in August Health (EMAR system) daily x1 week, then 3 times a week x 4 weeks, then 2 times a week x 4 weeks, then weekly x 4 weeks, then monthly for 1 month. 5 Systemic changes will be completed by 6/27/25.	

	The physician's order, dated 5/2/25, indicated the resident was to receive Donepezil HCl (hydrochloride) 10 mg twice daily for dementia at 8:00 a.m. and 8:00 p.m. The June 2025 medication administration record lacked documentation of the administration of the resident's Donepezil on 6/8/25 at 8:00 p.m. The physician's order, dated 6/3/25, indicated the resident was to receive Quetiapine (medication used for depression) 12.5 mg twice daily at 8:00 a.m. and 8:00 p.m. The June 2025 medication administration record lacked documentation of the administration of the resident's Quetiapine on 6/8/25 at 8:00 p.m. During an interview, on 6/11/25 at 11:15 a.m., Licensed Practical Nurse (LPN) 5 indicated after a medication was administered, the medication should be signed out on the medication administration record to show the medication was administered. On 6/11/25 at 1:12 p.m., the Executive Director provided a copy of the document titled "Community Team Members Procedures For Medication Assistance" dated 8/17. It			

included, but was not limited to, "Initial in the appropriate space on the Resident's Medication Administration Record (MAR)...for that day and time (also Community Team Members must sign the MAR...)...."

This Citation relates to Complaint IN00460885

Based on interview and record review, the facility failed to ensure a resident's (Resident E) medication administration record reflected the Health Services for 1 of 3 residents reviewed for medication administration.

Findings include:

The clinical record for Resident E was reviewed on 6/10/25 at 4:22 p.m. The resident's diagnoses included, but were not limited to, insomnia, depression and dementia.

The physician's order, dated 5/20/25, indicated the resident was to receive Trazodone (medication for insomnia) 50 mg (milligrams) at 8:00 p.m.

The June 2025 medication administration record lacked documentation of the administration of the resident's Trazodone on 6/8/25 at 8:00 p.m.

The physician's order, dated

	5/2/25, indicated the resident was to receive Donepezil HCl (hydrochloride) 10 mg twice daily for dementia at 8:00 a.m. and 8:00 p.m. The June 2025 medication administration record lacked documentation of the administration of the resident's Donepezil on 6/8/25 at 8:00 p.m. The physician's order, dated 6/3/25, indicated the resident was to receive Quetiapine (medication used for depression) 12.5 mg twice daily at 8:00 a.m. and 8:00 p.m. The June 2025 medication administration record lacked documentation of the administration of the resident's Quetiapine on 6/8/25 at 8:00 p.m. During an interview, on 6/11/25 at 11:15 a.m., Licensed Practical Nurse (LPN) 5 indicated after a medication was administered, the medication should be signed out on the medication administration record to show the medication was administered. On 6/11/25 at 1:12 p.m., the Executive Director provided a copy of the document titled "Community Team Members Procedures For Medication Assistance" dated 8/17. It included, but was not limited to,			

	"Initial in the appropriate space on the Resident's Medication Administration Record (MAR)...for that day and time (also Community Team Members must sign the MAR...)...." This Citation relates to Complaint IN00460885			
R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to ensure a resident's (Resident B) medications were available to administer for 1 of 3 residents reviewed for pharmacy services. Findings include: The clinical record for Resident B was reviewed on 6/10/25 at 3:10 p.m. The resident's diagnoses included, but were not limited to, dementia and unspecified male sexual	R 0297	1. The Community reviewed Resident B's active medication orders to confirm that Resident E's MAR is correct. Resident B is now receiving all prescribed medication. The Community informed Resident B's physician regarding the missed medication doses. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. The WD will complete 1-on-1 in-service/coachable moments with each QMA/Nurse for the unavailable medication process. This will be completed by 6/27/25.	06/27/2025

dysfunction.

The physician's order, dated 3/18/25, indicated the resident was to have an Estradiol 0.1 mg (milligram) transdermal patch topically every week on Wednesday.

Review of the April 2025 medication administration record indicated the resident did not receive the Estradiol transdermal patch due to not available.

The clinical record lacked documentation of the physician and pharmacy notification related to the unavailability of the resident's Estradiol transdermal patch.

During an interview, on 6/11/25 at 1:22 p.m., the Executive Director indicated the facility was responsible to ensure the residents medications were available.

On 6/11/25 at 1:05 p.m., the Executive Director provided a portion of the pharmacy services policy, requested on 6/11/25 at 12:50 p.m., and dated 8/17. It included, but was not limited to, "If the medication had not arrived from the pharmacy as scheduled, follow up should be made every shift by phone call to the pharmacy to find status...."

This Citation relates to

3. To ensure the deficient practices do not recur, the WD or designee is to audit the Unavailable Medications noted under Unavailable Medications Tab in August Health (EMAR system) daily x1 week, then 3 times a week x 4 weeks, then 2 times a week x 4 weeks, then weekly x 4 weeks, then monthly for 1 month.

4. Systemic changes will be completed by 6/27/25.

Complaint IN00460885

Based on interview and record review, the facility failed to ensure a resident's (Resident B) medications were available to administer for 1 of 3 residents reviewed for pharmacy services.

Findings include:

The clinical record for Resident B was reviewed on 6/10/25 at 3:10 p.m. The resident's diagnoses included, but were not limited to, dementia and unspecified male sexual dysfunction.

The physician's order, dated 3/18/25, indicated the resident was to have an Estradiol 0.1 mg (milligram) transdermal patch topically every week on Wednesday.

Review of the April 2025 medication administration record indicated the resident did not receive the Estradiol transdermal patch due to not available.

The clinical record lacked documentation of the physician and pharmacy notification related to the unavailability of the resident's Estradiol transdermal patch.

During an interview, on 6/11/25 at 1:22 p.m., the Executive Director indicated the facility was responsible to ensure the

	residents medications were available. On 6/11/25 at 1:05 p.m., the Executive Director provided a portion of the pharmacy services policy, requested on 6/11/25 at 12:50 p.m., and dated 8/17. It included, but was not limited to, "If the medication had not arrived from the pharmacy as scheduled, follow up should be made every shift by phone call to the pharmacy to find status...." This Citation relates to Complaint IN00460885			

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