

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER RIVERBEND		STREET ADDRESS, CITY, STATE, ZIP CODE 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 466203 and 466205. Intake 466203 - No deficiencies related to the allegation is cited. Intake 466205 - No deficiencies related to the allegations are cited. Survey date: November 23 and 24, 2025 Facility number: 010885 Residential Census: 83 Riverbend was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Intakes 466203 and 466205. Quality review completed on November 24, 2025.	R 0000			
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			TITLE	(X6) DATE	

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FORM APPROVED

OMB NO. 0938-0391

PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		
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