STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	01/19/2022

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 Complaints IN00363722, IN00370169, and a Residential COVID-19 Quality Assurance Walk Through. Complaint IN00363722 - Unsubstantiated due to lack of sufficient evidence. Complaint IN00370169 - Substantiated. No deficiencies related to the allegations are cited. Unrelated deficiencies are cited Survey dates: January 18 and 19, 2022 Facility number: 010885 Residential Census: 105 These State residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 26, 2022.	R 0000	This Plan of Correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of Riverbend Assisted Living as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or criminal action against the community or any employee, agent, officer, director, attorney or shareholder of the Community or affiliated companies.	

R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be 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 resident to resident abuse did not occur for 6 of 9 residents reviewed for Abuse. (Residents K, L, H, D, B, and C) Findings include: 1. The clinical record for Resident K was reviewed on 1/19/22 at 12:45 p.m. Diagnosis included, but was not limited to, dementia. The incident report, dated 10/7/21 at 11:28 a.m., indicated Resident K was hit by Resident B with an open hand on the left side of the head. The nurse's note, dated 10/7/21 at 11:28 a.m., indicated the resident was sitting in the dining room preparing to eat lunch	R 0052	#1. Resident B was moved to another room without a roommate. Resident B currently is in a room without a roommate. Community is working with residents' POA to find alternate placement. Res G was sent to Brightwell Behavior/Psyche hospital and remains there at this time. Resident D has had no further incidents of hitting other residents. Resident C is no longer a room mate with Res B. He has been pleasant and cooperative since incident occurred. #2. The Community reviewed each residents' records to determine which residents if any could be affected by the alleged deficient practice. #3. All staff will be in-serviced on the Community's Abuse Prevention policy. In addition, all residents will have a preadmission assessment per policy. Any history of behaviors will be discussed by the team and a plan with interventions will be written. The	02/16/2022

	when a peer walked in and struck the resident on the left side of the head. During an interview on 1/19/22 at 1:59 p.m., CNA (Certified Nursing Assistant) 3 indicated she had witnessed the incident and Resident B walked up and slapped Resident K for no reason. The clinical record for Resident B was reviewed on 1/18/22 at 10:38 a.m. Diagnosis included, but was not limited to, dementia with behavioral disturbance. The incident report, dated 10/7/21 at 11:28 a.m., indicated Resident B walked through the dining room and hit Resident K, with an open hand, on the left side of the head. The nurses' note, dated 10/7/21 at 11:28 a.m., indicated the resident was walking through the dining room and struck another resident on the left of the head with an open hand. The resident was placed one on one until sent out to the hospital for evaluation. 2. The clinical record for Resident L was reviewed on 1/19/22 at 1:03 p.m. Diagnosis included, but was not limited to, vascular dementia. The incident report, dated 10/25/21 at 12:30 a.m., indicated Resident L was struck		written plan with interventions will be followed by the nursing staff in order to monitor for any signs that the behavior(s) may be getting ready to occur, in an attempt to prevent the behavior(s) prior to abuse occurrences. #4. A third- party vendor will provide Behavior Monitoring sheets to be filled out by the nursing staff every shift. Written plans will be added as needed with interventions that are to be carried out by nursing staff if and when behaviors occur. If a resident is unable to be redirected and/or behavior presents possibility of harm to self or others an order will be obtained to send resident to Behavior/Psyche hospital. The resident will be placed on one-on-one staffing until sent out. Upon return to the community the resident will be placed on every 15 minute checks for 24 hours; then every 30 minute checks for 24 hours; then every hour for 24 hours and then the usual every 2 hours thereafter. Should behaviors continue the resident will be monitored and a behavior plan with interventions will be	

	on the side of his head by Resident B. The nurse's note, dated 10/25/21 at 1:00 a.m., indicated Resident L was resting quietly in bed when Resident B hit him several times in the temporal area. The residents were immediately separated. The clinical record for Resident B was reviewed on 1/18/22 at 10:38 a.m. Diagnosis included, but was not limited to, dementia with behavioral disturbance. The incident report, dated 10/25/21 at 12:30 a.m., indicated Resident B struck Resident L on the side of the head. The nurse's note, dated 10/25/21 and untimed, indicated Resident B had an altercation with Resident L and struck him three times, very hard, in the temporal area. Resident B was sent to the hospital for evaluation. 3. The clinical record for Resident H was reviewed on 1/19/22 at 10:57 a.m. Diagnosis included, but was not limited to, dementia. The incident report, dated 11/16/21 at 11:01 a.m., indicated Resident H was struck with a cane by Resident D. The nurse's note, dated		followed and/or another visit to Behavior/Psyche hospital will be arranged while seeking other placement. #5. The Wellness Director, Asst Wellness Director or designee will audit the Behavior Monitoring sheets weekly for 3 months; then every 2 weeks for 3 months; then every month for 3 months and then every 3 months for 6 months and then every 6 months thereafter to assure that the interventions are being followed.	

	11/16/21 at 11:00 a.m., indicated Resident H was struck on the leg with a cane by Resident D, whom admitted to striking the resident. The residents were immediately separated. The clinical record for Resident D was reviewed on 1/18/22 at 12:21 p.m. Diagnosis included, but was not limited to, dementia. The incident report, dated 11/16/21 at 11:01 a.m., indicated Resident D struck Resident H's leg with a cane. 4. The clinical record for Resident D was reviewed on 1/18/22 at 12:21 p.m. Diagnosis included, but was not limited to, dementia. The nurse's note, dated 12/12/21, indicated Resident D was in the common area sitting next to Resident B. When approached, Resident B was observed with his hand placed down Resident D's pants. Both residents were redirected and educated/reminded that the behavior was not appropriate for the common area. During an interview on 1/18/22 at 1:12 p.m., the Wellness Director indicated the incident was not reported as it was consensual. The clinical record lacked documentation of family consent			

until after the incident occurred.

The clinical record for Resident B was reviewed on 1/18/22 at 10:38 a.m. Diagnosis included, but was not limited to, dementia with behavioral disturbance.

The nurse's note, dated 12/12/21 at 9:40 a.m., indicated the resident was in the common area and observed with his hand down Resident D's pants.

5 (a). The clinical record for Resident B was reviewed on 1/18/22 at 10:38 a.m. Diagnosis included, but was not limited to, dementia with behavioral disturbance.

The incident report, dated 1/13/22 at 6:15 a.m., indicated Resident B ambulated to the common area, from his room, and was observed to have blood on his left ear. After assessment, the resident had an abrasion and discoloration to the left ear. Resident C then came to the common area with a broken vase in his hand and reported Resident B had threatened him, so he hit him with a vase.

The nurse's note, dated 1/13/22 at 9:30 a.m., indicated Resident B ambulated to the common bleeding around his left ear after an altercation with his roommate. The left ear was cleansed and a small one-inch scratch was found near the ear

lobe with bruising on the ear cartilage.

(b). The clinical record for C was reviewed on 1/18/22 at 11:59 a.m. Diagnosis included, but was not limited to, dementia with behavior disturbance.

The incident report, dated 1/13/22 at 6:15 a.m., indicated Resident C hit Resident B with a vase.

The nurse's note, dated 1/13/22 at 9:30 a.m., indicated at approximately 6:15 a.m., Resident C ambulated to the common area and reported that Resident B threatened to kill him so he hit him with a vase.

During an interview on 1/19/22 at 10:45 a.m., LPN (Licensed Practical Nurse) 4 indicated Resident C had walked to the common area and reported he had hit his roommate with a vase. Resident C still had the vase handle in his hand. He reported that Resident B leaned over him in the dark and told him he was going to kill him, so he hit him with the vase.

6. The clinical record for Resident D was reviewed on 1/18/22 at 12:21 p.m. Diagnosis included, but was not limited to, dementia.

The incident report, dated 1/14/22 at 4:30 p.m., indicated Resident D was struck by

	Resident G in the face and on the back. The nurse's note, dated 1/14/22 at 5:00 p.m., indicated the resident was sitting in the dining room in her wheelchair when another resident walked by and hit her in the face and back with an open hand. During an interview on 1/19/22 at 1:59 p.m., CNA 3 indicated on 1/14/22 at around 4:30 p.m., she was assisting residents to the dining room. Resident D was sound asleep in her wheelchair when Resident G walked past and slapped Resident D on the face and back. The clinical record for Resident G was reviewed on 1/18/22 at 1:48 p.m. Diagnosis included, but was not limited to, dementia. The incident report, dated 1/14/22 at 4:30 p.m., indicated Resident G struck Resident D, with an open hand, on the face and back. The nurse's note, dated 1/14/22 at 5:00 p.m., indicated the resident struck another resident on the face and back with an open hand. During an interview on 1/19/22 at 10:58 a.m., CNA 7 indicated they have always work with three aides during the day.			

	During an interview on 1/19/22 at 1:15 p.m., the Executive Director indicated the facility had admitted residents with a history of behavviors. Review of the facility staffing logs during the survey period, indicated there was no increase in the number of staff on day shift. On 1/19/22 at 2:05 p.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, "Policy...It is the policy of this Facility to protect residents from abusive acts...Abuse...The willful infliction of injury...Physical Abuse...hitting...slapping...." Based on interview and record review, the facility failed to ensure resident to resident abuse did not occur for 6 of 9 residents reviewed for Abuse. (Residents K, L, H, D, B, and C) Findings include: 1. The clinical record for Resident K was reviewed on 1/19/22 at 12:45 p.m. Diagnosis included, but was not limited to, dementia.			

	The incident report, dated 10/7/21 at 11:28 a.m., indicated Resident K was hit by Resident B with an open hand on the left side of the head. The nurse's note, dated 10/7/21 at 11:28 a.m., indicated the resident was sitting in the dining room preparing to eat lunch when a peer walked in and struck the resident on the left side of the head. During an interview on 1/19/22 at 1:59 p.m., CNA (Certified Nursing Assistant) 3 indicated she had witnessed the incident and Resident B walked up and slapped Resident K for no reason. The clinical record for Resident B was reviewed on 1/18/22 at 10:38 a.m. Diagnosis included, but was not limited to, dementia with behavioral disturbance. The incident report, dated 10/7/21 at 11:28 a.m., indicated Resident B walked through the dining room and hit Resident K, with an open hand, on the left side of the head.			

	The nurses' note, dated 10/7/21 at 11:28 a.m., indicated the resident was walking through the dining room and struck another resident on the left of the head with an open hand. The resident was placed one on one until sent out to the hospital for evaluation. 2. The clinical record for Resident L was reviewed on 1/19/22 at 1:03 p.m. Diagnosis included, but was not limited to, vascular dementia. The incident report, dated 10/25/21 at 12:30 a.m., indicated Resident L was struck on the side of his head by Resident B. The nurse's note, dated 10/25/21 at 1:00 a.m., indicated Resident L was resting quietly in bed when Resident B hit him several times in the temporal area. The residents were immediately separated. The clinical record for Resident B was reviewed on 1/18/22 at 10:38 a.m. Diagnosis included, but was not limited to, dementia with behavioral disturbance. The incident report, dated 10/25/21 at 12:30 a.m., indicated Resident B struck Resident L on the side of the head. The nurse's note, dated 10/25/21 and untimed, indicated			

	Resident B had an altercation with Resident L and struck him three times, very hard, in the temporal area. Resident B was sent to the hospital for evaluation. 3. The clinical record for Resident H was reviewed on 1/19/22 at 10:57 a.m. Diagnosis included, but was not limited to, dementia. The incident report, dated 11/16/21 at 11:01 a.m., indicated Resident H was struck with a cane by Resident D. The nurse's note, dated 11/16/21 at 11:00 a.m., indicated Resident H was struck on the leg with a cane by Resident D, whom admitted to striking the resident. The residents were immediately separated. The clinical record for Resident D was reviewed on 1/18/22 at 12:21 p.m. Diagnosis included, but was not limited to, dementia. The incident report, dated 11/16/21 at 11:01 a.m., indicated Resident D struck Resident H's leg with a cane. 4. The clinical record for Resident D was reviewed on 1/18/22 at 12:21 p.m. Diagnosis included, but was not limited to, dementia. The nurse's note, dated			

	12/12/21, indicated Resident D was in the common area sitting next to Resident B. When approached, Resident B was observed with his hand placed down Resident D's pants. Both residents were redirected and educated/reminded that the behavior was not appropriate for the common area. During an interview on 1/18/22 at 1:12 p.m., the Wellness Director indicated the incident was not reported as it was consensual. The clinical record lacked documentation of family consent until after the incident occurred. The clinical record for Resident B was reviewed on 1/18/22 at 10:38 a.m. Diagnosis included, but was not limited to, dementia with behavioral disturbance. The nurse's note, dated 12/12/21 at 9:40 a.m., indicated the resident was in the common area and observed with his hand down Resident D's pants. 5 (a). The clinical record for Resident B was reviewed on 1/18/22 at 10:38 a.m. Diagnosis included, but was not limited to, dementia with behavioral disturbance. The incident report, dated 1/13/22 at 6:15 a.m., indicated Resident B ambulated to the common area, from his room,			

and was observed to have blood on his left ear. After assessment, the resident had an abrasion and discoloration to the left ear. Resident C then came to the common area with a broken vase in his hand and reported Resident B had threatened him, so he hit him with a vase.

The nurse's note, dated 1/13/22 at 9:30 a.m., indicated Resident B ambulated to the common bleeding around his left ear after an altercation with his roommate. The left ear was cleansed and a small one-inch scratch was found near the ear lobe with bruising on the ear cartilage.

(b). The clinical record for C was reviewed on 1/18/22 at 11:59 a.m. Diagnosis included, but was not limited to, dementia with behavior disturbance.

The incident report, dated 1/13/22 at 6:15 a.m., indicated Resident C hit Resident B with a vase.

The nurse's note, dated 1/13/22 at 9:30 a.m., indicated at approximately 6:15 a.m., Resident C ambulated to the common area and reported that Resident B threatened to kill him so he hit him with a vase.

During an interview on 1/19/22 at 10:45 a.m., LPN (Licensed Practical Nurse) 4 indicated

Resident C had walked to the common area and reported he had hit his roommate with a vase. Resident C still had the vase handle in his hand. He reported that Resident B leaned over him in the dark and told him he was going to kill him, so he hit him with the vase.

6. The clinical record for Resident D was reviewed on 1/18/22 at 12:21 p.m. Diagnosis included, but was not limited to, dementia.

The incident report, dated 1/14/22 at 4:30 p.m., indicated Resident D was struck by Resident G in the face and on the back.

The nurse's note, dated 1/14/22 at 5:00 p.m., indicated the resident was sitting in the dining room in her wheelchair when another resident walked by and hit her in the face and back with an open hand.

During an interview on 1/19/22 at 1:59 p.m., CNA 3 indicated on 1/14/22 at around 4:30 p.m., she was assisting residents to the dining room. Resident D was sound asleep in her wheelchair when Resident G walked past and slapped Resident D on the face and back.

The clinical record for Resident G was reviewed on 1/18/22 at 1:48 p.m. Diagnosis included,

	but was not limited to, dementia. The incident report, dated 1/14/22 at 4:30 p.m., indicated Resident G struck Resident D, with an open hand, on the face and back. The nurse's note, dated 1/14/22 at 5:00 p.m., indicated the resident struck another resident on the face and back with an open hand. During an interview on 1/19/22 at 10:58 a.m., CNA 7 indicated they have always work with three aides during the day. During an interview on 1/19/22 at 1:15 p.m., the Executive Director indicated the facility had admitted residents with a history of behavviors. Review of the facility staffing logs during the survey period, indicated there was no increase in the number of staff on day shift. On 1/19/22 at 2:05 p.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, "Policy...It is the policy of this Facility to protect residents from abusive acts...Abuse...The willful infliction of injury...Physical Abuse...hitting...slapping...."			

R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.	R 0090	#1. Resident D and Resident B continue to reside on the same unit. They are being monitored frequently by staff for any inappropriate behaviors and/or inappropriate physical contact. The Family members of both residents are aware of the attraction the two (2) residents have to one another and have signed Service plans. #2. The Community reviewed each residents record to determine which residents if any could be affected by the alleged deficient practice. #3. All staff will be in-serviced on the Community’s Abuse Prevention policy and on reporting incidents to the appropriate agencies, including the IDOH. Any inappropriate behaviors will be reported to the Wellness Director, Asst Wellness Director who will then report to the Executive Director. Any and all occurrences that are considered to be reportable will be reported in the allotted time frame to the appropriate agency. In addition, Behavior Monitoring sheets will be filled out by nursing every shift. All nursing staff will be in-serviced	02/16/2022

	(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on interview and record review, the facility failed to ensure resident to resident abuse was reported to the appropriate agencies, including the Indiana Department of Health, for 1 of 8 residents reviewed for abuse.		by the Wellness Director and/or the Asst Wellness Director on the use of the Behavior Monitoring sheets. #4. All behaviors from the previous twenty- four (24) hours will be presented by the Wellness Director and/or the Assistant Wellness Director in the Morning Meeting to assure that any and all reportable incidents were reported timely to the ED and also to the Division to ensure the deficient practice does not reoccur. #5. The Wellness Director, Asst Wellness Director or designee will audit the Behavior Monitoring sheets weekly for 3 months; then every 2 weeks for 3 months; then monthly for 3 months, then every 3 months for 6 months and then every 6 months thereafter to assure that the interventions are being followed.	

The clinical record for Resident D was reviewed on 1/18/22 at 12:21 p.m. Diagnosis included, but is not limited to, dementia.

The nurse's note, dated 12/12/21, indicated Resident D was in the common area sitting next to Resident B. When approached, Resident B was observed with his hand placed down Resident D's pants. Both residents were redirected and educated/reminded that the behavior was not appropriate for the common area.

The clinical record for Resident B was reviewed on 1/18/22 at 10:38 a.m. Diagnosis included, but was not limited to, dementia with behavioral disturbance.

The nurse's note, dated 12/12/21 at 9:40 a.m., indicated the resident was in the common area and observed with his hand down Resident D's pants.

During an interview on 1/18/22 at 1:12 p.m., the Wellness Director indicated she did not report the incident as it was consensual.

On 1/19/22 at 2:05 p.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, "Policy...The Facility will comply with state and federal regulations for reporting...actual acts of

abuse...."

Based on interview and record review, the facility failed to ensure resident to resident abuse was reported to the appropriate agencies, including the Indiana Department of Health, for 1 of 8 residents reviewed for abuse.

The clinical record for Resident D was reviewed on 1/18/22 at 12:21 p.m. Diagnosis included, but is not limited to, dementia.

The nurse's note, dated 12/12/21, indicated Resident D was in the common area sitting next to Resident B. When approached, Resident B was observed with his hand placed down Resident D's pants. Both residents were redirected and educated/reminded that the behavior was not appropriate for the common area.

The clinical record for Resident B was reviewed on 1/18/22 at 10:38 a.m. Diagnosis included, but was not limited to, dementia with behavioral disturbance.

The nurse's note, dated 12/12/21 at 9:40 a.m., indicated the resident was in the common area and observed with his hand down Resident D's pants.

During an interview on 1/18/22 at 1:12 p.m., the Wellness Director indicated she did not report the incident as it was

	consensual. On 1/19/22 at 2:05 p.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, "Policy...The Facility will comply with state and federal regulations for reporting...actual acts of abuse...."			

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