

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 01/25/2024	
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 a Post Survey Revisit (PSR) to Investigation of Complaint IN00422665 completed on December 18, 2023. This visit was in conjunction with the PSR to Investigation of Complaint IN00421583 completed on November 16, 2023. Complaint IN00422665 - Corrected Complaint IN00421583 - Corrected Survey date: January 24, 2024 Facility number: 010885 Residential Census: 90 Riverbend was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00422665. Quality review completed on	R 0000					

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	January 30, 2024. This visit was for a Post Survey Revisit (PSR) to Investigation of Complaint IN00422665 completed on December 18, 2023. This visit was in conjunction with the PSR to Investigation of Complaint IN00421583 completed on November 16, 2023. Complaint IN00422665 - Corrected Complaint IN00421583 - Corrected Survey date: January 24, 2024 Facility number: 010885 Residential Census: 90 Riverbend was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00422665. Quality review completed on January 30, 2024.			
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;	R 0052		

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FORM APPROVED

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OMB NO. 0938-0391

	(2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion.			
R 0053	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(w) (w) Residents have the right to be free from verbal abuse.	R 0053		
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