STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/17/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00433811. Complaint IN00433811 - No deficiencies related to the allegation is cited. Unrelated deficiency cited. Survey date: June 17, 2024 Facility number: 010885 Residential Census: 87 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. 'Quality review completed on June 19, 2024.	R 0000		
R 0029 Bldg. 00	410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on observation, interview and record review, the facility failed to ensure a resident's (Resident C) rights remained intact for 1 of 4 residents reviewed for dignity. Findings include: The clinical record for Resident C was reviewed on 6/17/24 at 1:55 p.m. The diagnoses included, but were not limited to, anxiety and insomnia. On 6/17/24 at 1:45 p.m., Resident C was observed in the activity room participating in an activity.	R 0029	**R 029 410 IAC 16.2-5-1.2(d) Residents' Rights** 1. Resident C rights are intact, and resident is being treated with dignity. QMA 4 is no longer employed by the Community. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. Resident rights in-service with all staff was completed on	07/01/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ricki Elston	Executive Director	07/01/2024

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	She had no signs of any psychosocial distress. The incident report, dated 4/21/24 at 8:15 p.m., indicated Resident C's daughter reported that QMA (Qualified Medication Aide) 4 was in Resident C's face last night and told her she had to take her medications now. The April 2024 medication administration record indicated the resident was to receive Ativan (anti-anxiety medication) 0.5 mg (milligrams) every night at bedtime and twice daily as needed for anxiety. The progress note, dated 4/22/24 at 3:06 p.m., indicated the WD (Wellness Director) was made aware of incident that occurred on 4/21/24. The resident was to be monitored for psychosocial well-being for 72 hours. The progress note, dated 4/22/24 at 8:14 p.m., indicated the resident had no signs or symptoms of psychosocial distress. The progress note, dated 4/23/24 at 1:34 p.m., indicated the resident had severe anxiety on that day during the morning and as needed Ativan was administered. The medication helped somewhat, however, the resident's hands were shaking uncontrollably. The progress note, dated 4/23/24 at 8:27 p.m., indicated to discontinue the as needed order for Ativan. A new order for Ativan 0.25 mg every morning and Paroxetine (anxiety medication) 12.5 mg every morning for panic disorder. The progress note, dated 4/24/24 at 4:12 a.m., indicated the resident had exhibited anxiety over the past week, at the same time, every morning		6/20/24, Resident rights in-service to be completed with all staff monthly for 3 months, then every other month for an additional 4 months, then annually thereafter. Wellness Director will in-service all medication staff on medication administration, including a Resident's right to refuse medication. 4. Wellness Director will conduct interviews with 3 Residents or Resident family members per week for 6 weeks to screen for any concerns with Community staff. Additionally, Wellness Director will observe 3 med passes per week for 6 weeks to ensure Resident Rights are being respected. 5. Systemic changes completed by 7/1/24	

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	during shift change. The resident would not put her call light on but would ambulate to the nurses' station shaking and crying. During an interview on 6/17/24 at 2:30 p.m., Resident C indicated the evening the incident occurred, she was in her apartment watching television with Resident E. QMA 4 brought in her evening medications to her between 7:30 p.m. and 8:15 p.m. She took all of her medications except for her nerve pill (Ativan), which she always took right before she went to bed. She placed the medication cup with her nerve pill on the table next to her recliner. QMA 4 grabbed the cup with her nerve pill. She told QMA 4 she had always taken her medications that way. She asked QMA 4 if she couldn't leave the medication, could she bring it back later right before she went to bed. QMA 4 told her "no, I'm getting ready to leave". QMA 4 bent over her and was in her face. She could not recall what QMA 4 said as she was crying and so upset. No one had ever spoke to her like that. "The way she said it was so hateful. I had never been so upset thinking I would not get my nerve pill". On 6/117/24 at 3:55 p.m., the Executive Director provided a current copy of the document titled "Indiana Residents Rights for Residential Care" dated March 1, 2023. It included, but was not limited to, "The resident has a right to have his/her rights recognized by the community...The resident has the right to a dignified existence...The resident has the right to be treated with consideration, respect and recognition of their dignity and individuality...." During an interview on 6/17/24 at 2:40 p.m., Resident E indicated she was in Resident C's apartment watching television when QMA 4 came			

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	in to give Resident C her medication. At first, she did not pay that much attention. She looked over and observed the nurse grab the medication cup up from the table. She told Resident C she would not bring her nerve pill back because she was leaving. "I had never seen Resident C shake so bad. QMA 4 was in her face and Resident C was crying and so upset".			