STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155621	A. BUILDING 00 B. WING	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVER BEND NURSING AND REHABILITATION	3400 STOCKER DR EVANSVILLE, IN 47720

(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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00403979 and IN00406108. Complaint IN00403979 -No deficiencies related to the allegations are cited. Complaint IN00406108 - No deficiencies related to the allegations are cited. Unrelated deficiencies Survey dates: 4/12/23 to 4/14/23 Facility number: 000442 Provider number: 155621 AIM number: 100266510 Census Bed Type: SNF/NF: 53 SNF: 7 Total: 60 Census Payor Type: Medicare: 11 Medicaid: 41 Other: 8 Total: 60 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 21, 2023.	F 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered ae our allegation of compliance effective 5/12/2023. The facility respectfully is requesting paper compliance for this citation.	
F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation §483.12 The resident has the right to be free from			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christine Goad	HFA	05/02/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Based on interview and record review, the facility failed to ensure a resident was free from misappropriation of their property for 1 of 3 residents reviewed for misappropriation of drugs. Narcotics were unaccounted for after delivery to facility. (Resident 22) Findings includes: On 4/12/23 at 2:15 P.M., reviewed the facility reportable's incidents. A report dated on 1/4/23 indicated "On 1/3/23 at 3:30 A.M., Nursing was unable to locate a card of Lortab for Resident 22." The investigation was initiated and indicated that all medication carts were reconciled with no further discrepancies noted. The MD (Medical Doctor), family, Pharmacy, and Evansville Police Department were notified. A search for the missing Lortab card was started. The medication was immediately re-dispersed from Pharmacy. Medication reconciliation will be done daily by the DON/or designee. On 4/14/23 at 10:30 A.M., Resident 22's clinical record was reviewed. Diagnosis included but not limited to, pain in right shoulder and lower back pain unspecified. The most recent annual MDS (minimum data set) Assessment, dated 3/24/23, indicated that Resident 22 was cognitively impaired and received scheduled pain medications. Current physician orders included, but were not	F 0602	**It is the practice of this facility to assure that residents will be free from abuse, neglect, misappropriation of resident property, and exploitation.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident H has had his medication replaced by the facility. ***Other residents that have the potential to be affected have been identified by:*** All residents have been reviewed to assure that narcotic medications have been logged and tracked appropriately. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** An inservice has been conducted for nurses and QMA's to ensure staff know how to receive, inventory, and count narcotics; including completing narcotic logs along with education on notification of Administrator when there is a discrepancy in narcotic count logs.	05/12/2023

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	limited to, the following: Lortab Tablet 7.5-325 mg (Milligrams), give 1 tablet by mouth every 6 hours for pain, dated 11/14/22. A current care plan dated 6/15/21, included but was not limited to, an intervention to administer pain medication as per MD order and note effectiveness. On 4/13/23 at 1100 A.M., the MAR(Medication Administration Record) for the month of January 2023,was reviewed and indicated the resident received medications at every 6 hours at 1200 A.M.,6:00 A.M.,1200 P.M., and 6:00 P.M., as ordered. The resident did not miss any scheduled doses During an interview on 4/13/23 at 9:22 A.M., the DON indicated she was notified by LPN (Licensed Practical Nurse) 5 that there was a missing card of Lortab 7.5/325 mg on 1/3/23. She indicated that she received statements from RN (registered nurse) 6 and LPN 4 who were involved in the incident. She indicated how the medications/narcotics were received from the pharmacy. The accepting nurse will receive the shipment of the medications from the pharmacy tech. The receiving RN or LPN will review the medication list from the pharmacy with the driver. The 2 will proceed to review the inventory verifying each medication/ narcotic count on each medication card. If the count on the inventory list is ok, the receiving nurse will place the narcotics for her area in the appropriate medication cart along with any other refills for other residents. If there is a discrepancy, the list is marked with what is missing. The staff would then tell the driver, who would call pharmacy. The nursing staff would also notify the pharmacy. If		***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews 5 resident narcotic count sheets to ensure that narcotic counts are being completed with every shift change including counting narcotic cards and narcotic count sheets. The PI tool will also observe 5 staff members during controlled substance counting to assure completed accurately. The Director of nursing, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.	

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	medication must be replaced,the nurse would sign a refill notification and the send to pharmacy with an explanation of early refill. The DON indicated that the initial narcotic count on 12/29/22 for the drug shipment delivery was correct on this day. The resident had enough medications to cover until 1/2/23. The resident did not miss any scheduled doses. The missing card was discovered on 1/3/23. There were statements taken by the DON from the 2 staff members involved. On 4/12/23 at 2:15 P.M., the statement taken from LPN 4, indicated that she had received the medications from the pharmacy at 10:00 P.M. She could not recall the exact narcotics, counted it card, and signed for the lot. She took her cards, placing them in the medication cart on her assigned unit (South). RN 6 took her medication cards to her assigned medication cart on North Hall. From the statement received from DON, indicating the above findings from LPN 4. RN 6 indicated " she did not receive medications or narcotic sheets from LPN 4." The statement also indicated RN 6 left at 10:32 P.M., and the medication with cards had not delivered. The DON indicated that RN 6 had signed the narcotic sheet." On 4/14/23 at 11:23 A.M., a police report was presented by DON (Director of Nursing). The case number is 23-00209. The incident was reported on 1/4/23 at 1:37 P.M., "the investigation revealed that there were 30 (thirty) Lortab pills were missing from one pharmacy." On 4/14/23 at 10:55 A.M., during a interview with DON. They reported on 1/3/23 because the drugs and the card to go with them were both missing			

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	on 12/29. If there were no drugs and no card, the drugs would not be included in the count. They count narcotics every shift. On 1/3/23, they found the card on the shredder machine, so realized the drugs were missing and reported it. On 4/14/23, at 11:14 A.M., an attempt to call RN 6 was made and no answer was obtained. On 4/14/23, at 11:23 A.M., an attempt to call LPN 4 was made and no answer was obtained. On 4/14/23 at 9:27 A.M., a current "Controlled Medications" policy dated 6/21/22 was provided and indicated "Medications included in the Drug Enforcement Administration(DEA) classification as controlled substances are subject to special handling, storage,disposal, and record keeping in the facility, in accordance with federal and state laws and regulations. Procedure 1. The Director of Nursing and the consultant pharmacist maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications. Only authorized licensed nursing and pharmacy personnel have access to controlled medications." On 4/14/23 at 9:27 A.M., a current "Abuse Policy" dated 1/2020 was provided and indicated "The resident has the right to be free from abuse... misappropriation...as defined in this subpart...The Facility shall have processes in place to include...investigation, reporting, and response to allegations of potential or actual abuse or neglect ...Definitions...Misappropriations of resident property: is defined as a deliberate misplacement...use of a resident's belongings...without the resident's consent." 3.1-28(a)			

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