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	11/16/2023

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 IN00421583. Complaint IN00421583 - Substantiated. State deficiency related to the allegation is cited at R0052. Survey date: November 16, 2023. Facility number: 010885 Residential Census: 87 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on November 27, 2023.	R 0000	This Plan of Correction is submitted as required under State law. The submission of this Plan of Correction does not constitute an admission on the part of Riverbend as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. The submission of this Plan of Correction 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 judicial and/or administrative proceeding on that basis. The Community also 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	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melusine McDaniel	Operations Specialist	12/04/2023

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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Bldg. 00	(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 provide a safe environment and prevent an elopement for 1 of 3 residents reviewed for Neglect which resulted in a resident eloping from the facility through 2 exit doors with alarm failures. (Resident B) Findings include: The record for Resident B was reviewed on 11/16/23 at 10:19 a.m. The diagnoses included, but were not limited to, altered mental status and dementia. The progress note, dated 11/9/23 at 5:17 a.m., indicated at 4:40 a.m. the QMA (Qualified Medication Aide) went to the resident room to give her 5:00 a.m. medications. When she walked in, the resident was not in her bed. She immediately alerted the CNA's (Certified Nurse Aides) on duty with her that evening, and they started looking for the resident. The C Hall door was found ajar, and they saw a hallway with a door that led outside. Staff went out the door but did not see the resident. The Wellness Director was contacted while staff looked further for the resident. The CNA's heard someone yelling, and staff started looking outside the facility. Resident B was found by CNAs outside the facility. The resident was brought back inside at 4:46 a.m. The progress note, dated 11/9/23 at 6:08 a.m., indicated the nurse had done a head-to-toe	R 0052	Resident B's environment has been addressed to meet state standards. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. Staff audited all doors on the Magnolia Trails unit (memory care) to ensure doors and alarms were in proper working order. The Community retained a third-party vendor to inspect and make any necessary repairs to Magnolia Trails exit doors. This included ordering three new maglocks. Additionally, a new call light and alarm system was implemented on November 29, 2023. Furthermore, the monthly elopement drill was completed on November 8, 2023, and the next elopement drill was completed on December 4, 2023. On November 26, 2023, all staff completed an abuse and neglect in-service; on November 27, 2023, all staff completed a resident rights in-service. Door checks will be completed by the Memory Care Director or designee three times daily for two	12/09/2023

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	assessment of the resident and found she had two 1.5-inch scratches on her posterior mid torso which were pinkish red in color with no break in the skin. The handwritten statement of CNA 3, dated 11/9/23, indicated QMA 2 came and asked if she had seen Resident B. She indicated no, and they began searching C Hall for the resident. QMA 2 realized the door, with a keypad, was ajar and unlocked. She walked outside looking for the resident, then went back in and went back out front to look for the resident. They received a phone call saying the resident was found out back. The resident was sitting on the hill. They assisted getting her back up and inside. The handwritten statement of CNA 4, dated 11/9/23, indicated QMA 2 had asked if she had seen the resident between 4:30 a.m. and 4:45 a.m. The last time she had seen the resident had been an hour or so prior, in the living room. They checked everywhere for the resident, and discovered a door which was not locked, despite having a pass code on it. It led out by the pond. She and CNA 5 found the resident out back, on the ground, outside. She was not too far from the pond, where the road could visibly be seen from a far distance. QMA 2 and CNA 3 were contacted to come and assist with helping the resident back into the facility. The hand-written statement of QMA 2, dated 11/9/23, indicated at 4:40 a.m., the QMA went to the resident room and noticed she was not in her bed. She could not locate the resident in her closet or her bathroom. She went and alerted her CNA's, and they started checking rooms, bathrooms, and laundry rooms. She noticed the C Hall door ajar. The door opened and led to		months, then two times daily for two months, and one time daily for two months to ensure proper working order. Systemic changes will be completed and in effect by December 9, 2023.	

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	another door that she was able to open which led to the outside pond area. She had CNA 3 with her, and she went around the side of the building but did not see anything. They then went out front and heard yelling and went running around the building. Resident B had been found on a hill in the grass. The DON was notified, and the resident was brought inside at 4:46 a.m. The handwritten statement of CNA 5, dated 11/9/23, indicated at 4:30 a.m. Resident B wasn't in her room. The staff members checked every room and then went outside. She and CNA 4 found the resident down the hill. She wasn't hurt. The last time she had checked on her was 2:00 a.m. and she had been in bed. The Insurance Claim reporting form, dated 11/9/23, indicated the resident was not in her room at 4:40 a.m. The resident was sitting outside in the grass outside of the building. The resident had last been seen in the common area at approximately 3:45 a.m. The bolt to the magnet on the C Hall door had come loose. The magnet stuck to the other part of the magnetic lock, and the alarm did not go off. The door was fixed, and the control company was called to ensure the system was in proper working order. The nurse's note, dated 11/10/23 at 2:29 p.m., indicated the nurse spoke with the resident's POA (Power of Attorney) who indicated "I don't doubt it, my mom used to leave and go for walks when she lived at home with me." During an observation on 11/16/23 at 11:16 a.m., the Memory Care Director (MCD) checked all the doors in the facility. All doors were observed to have a secondary alarm system on them, which consisted of a white two-part magnet. When the			

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	magnet was broken, such as when the door opened, the alarm would sound until the door was closed again. The secondary alarm on the B Hall interior was found to not be functioning. The MCD flipped a switch on the side of the alarm, and it began working again. The staff entrance interior door was also found to be malfunctioning. Upon exiting the door, the MCD entered the access code multiple times. The light would turn green, however the door would not open. The MCD had to call another staff member inside the building to allow her back in. During an interview, on 11/16/23 at 11:20 a.m., the MCD indicated they were checking the doors frequently. They had added a secondary alarm system so if one failed, they had a backup. They were checking the doors twice daily at minimum. When the B Hall alarm did not sound, she indicated staff must have turned it off when they went out the door on break, but not turned it back on. That was the secondary alarm. She was going to ask them not to turn it off, as the alarm only sounded for the few seconds the door was open. The Staff Entrance door had an issue where the door would not unlock at times. Their Alarm Control company was aware of the issue and had ordered some parts. During an interview, on 11/16/23 at 12:16 p.m., the DON indicated when Resident B had gotten out, the C Hall door that was ajar was the interior door. The door had an alarm and had a magnetic lock. The alarm did not go off because the magnetic lock failed. The bolt came loose from the door itself and both magnets stayed together so they never separated, causing the alarm to not go off. It was unlocked because the magnet wasn't connected so they could just push it open. The magnet should have been on the door, that was			

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	what held it locked. It totally failed. The exterior door did not alarm, and they did not know why. They had the Alarm Control company come out. They contacted them and they came out and checked the system but were not able to identify why it did not go off. They said it was a system failure. They had installed a secondary alarm system temporarily until everything was fixed. They bumped up the safety checks to three times daily, and they now had a night shift check. During an observation, on 11/16/23 at 12:30 p.m., the DON indicated the resident had been found by staff outside the C Hall door. The DON walked to the back of the building. To the left of the building there was a pond behind a chain link fence. To the right of the pond and the rear of the building there was a tree on top of a small hill. The DON indicated the resident had been located on or near the bottom of this small hill according to what staff had reported to her. The hill was within approximately 20 feet of the building. There was a road with moderate traffic visible in the distance from the location, with no barriers between where the resident was found and the road. During an interview on 11/16/23 at 1:32 p.m., the Maintenance Director indicated he didn't know anything about Resident B getting out other than what staff told him. What happened was the magnetic lock on the C Hall door, the nut came loose on the magnet, and she was able to open the door. The magnet stayed energized, so the alarm didn't sound. As to why the exterior door alarm didn't sound, he thought the alarm on the exterior door was not reset. They had to be manually reset. They had some work done in the area a couple weeks prior. He thought they went through that door, and when they closed it, they didn't reset the alarm. He was aware of the issues			

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	with the employee door not opening. They had their alarm control company coming in, they came in looked at our issues and had parts on order for the C Hall and the employee entrance. That's why they installed the secondary alarms. When the door opened the alarm would sound, but if the door closed it was silent. The control company had not told them how long it would be before they got the part. He educated the staff on how the secondary alarms functioned. He didn't tell them not to turn it off, he figured they would know better. When they had an alarm on the door, they did not turn it off. The electronic board for the exterior door on C Hall was bad. The reason it didn't alarm was that it wasn't reset. If someone walked through the door now, the alarm would sound, and it would continue to sound until someone went and silenced it. Then the alarm had to be reset for it to function again. When the alarm didn't sound it was because the alarm had not been reset. They'd had a company in there working and when they finished working the panel wasn't reset. They were going to try and set it up where when they silence the alarm it would automatically reset. During an interview, on 11/16/23 at 2:23 p.m., the DON indicated she was not made aware of the issue with the door having to be manually reset. She had the company coming back because it needed to alarm every time the door was opened and that was what they were having them do. They had not educated staff as to setting or resetting the alarms. She had not told them to not turn the alarms off, she was not aware of it being an issue. The outside air temperature on the early morning time frame the resident was found outside was approximately 56 degrees Fahrenheit.			

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	The most current Elopement Policy included, but was not limited to, "Elopement can be defined as a cognitively impaired resident's unassisted, unsupervised, unscheduled absence or departure from the community, thereby creating the potential for harm ... Recommendations to Improve Environmental Safety ... Inspect exit doors routinely ... Inspect security devices (exit door locks/alarms, resident bracelets, etc) regularly to make sure they are functioning properly ... This deficiency relates to Complaint IN00421583.			