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	01/16/2025

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 Complaints IN00442957, IN00444477, IN00447297 and IN00448084. Complaint IN00442957 - State deficiency related to the allegations is cited at R0154. Complaint IN00444477 - No deficiencies related to the allegations are cited. Complaint IN00447297 - State deficiency related to the allegations is cited at R0296. Complaint IN00448084 - State deficiency related to the allegation is cited at R0154. Survey dates: January 14, 15 and 16, 2024 Facility number: 010885 Residential Census: 82 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 22, 2025.	R 0000		
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency Based on observation, interview and record review, the facility failed to ensure the kitchen area was clean and maintained for 2 of 2 kitchen observations. This deficent practice had the potiential to affect 82 of 82 resident resideing in the facility.	R 0154	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	02/03/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Findings include: On 1/14/25 from 9:48 a.m. to 10:28 a.m., the following concerns were observed: -The smoke alarm/heat sensor was observed hanging down from the ceiling and not attached securely -The area between the kitchen sink and window was observed with no tile. The unattached tile was observed on the window sill and counter by the sink. -Below the kitchen sink cabinets, between the floor and cabinets, tile was missing and a black substance observed which spanned approximately two and one half feet. -The soffett, above the kitchen sink and cabinets, was observed with scattered gray particles of dust. - A white substance was observed along the floor edge by the kitchen sink. -There was a white splattered substance on the bottom of the freezer behind the door to the kitchen entrance. -There was splattered grease on the wall behind and to the right of the deep fryer. Splatter/dried spillage was observed under the food service window. -There were no doors to the upper cabinets where the food plates were stored. -Below the cabinet, next to the refrigerator, wood was missing which spanned 18 inches. The space was open underneath the cabinet. -The stove hood range had a paper towel stuffed under the left bottom edge.The top left edge of the hood was observed to be pulled away from the wall with a yellowish substance observed peeling off. A white fluffy substance with discolored strands were observed at the bottom of the hood over the stove.		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. 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; 3 What measures will be put into place or what systemic changes	

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	-Dust was observed behind the stove. -Dust particles, gray in color, were observed on the wall above the staff handwashing sink. -Dried spillage was observed next to, and below, the fire extinguisher on the wall. -In the dishwashing area, gray particles of dust were observed at the top of all the walls. The wall behind the dishwasher was obseved with splatter and dried spillage. During an interview on 1/14/25 at 10:05 a.m., the Dietary Manager indicated she had been trying to find something that would reach the dust. The white substance on the floor edge was a chemical that was sprayed to get the grease up. During an interview, on 1/14/25 between 9:48 a.m. to 2:15 p.m, Staff Member 4 indicated the wood had rotted there and below the kitchen sink. The paper towel was put under the left edge of the stove hood because it had fallen of and was glued back on. The white fluffy substance hanging out from the stove hood was insulation. On 1/14/25 at 2:09 p.m., the following concerns were observed in the Memory Care kitchen: -Dust particles were observed on the top of the wall above the cabinet next to the staff handwashing station. -The refrigerator vent was observed with gray dust particles. -The ceiling vent register, above the ice machine, was observed with a thick amount of gray dust particles. - The wall, directly below the vent register, was observed with gray dust particles. - The top of the cabinet, below the vent register, was observed with gray dust particles.		the facility will make to ensure that the deficient practice does not recur; 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?; and 5 By the date the systemic changes will be completed. R 154 1 The Dietary Director or designee to in-service all dietary staff on facility schedules for daily, weekly, and monthly cleaning by February 3, 2025. 2 The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. The Wellness Director audited the Infection Control log and noted no reports of food-related illnesses in the past 90 days. The Wellness Director or designee will continue to monitor for any signs/symptoms of illnesses and follow up as needed. 3 The Dietary Director or designee will audit and review daily cleaning logs daily for 6 weeks, then weekly thereafter; any missing initials of staff will be addressed immediately. The	

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	During an intervew on 1/14/25 between 9:48 a.m. to 2:15 p.m., Staff Member 5 indicated she could not reach the dust on the upper walls. The vent register was pretty dusty, however, she had asked for a vaccuum but could not obtain one. This Citation relates to Complaint IN00442957 and IN00448084		Dietary Director or designee will audit and review weekly cleaning logs weekly for 6 weeks, then monthly thereafter for 5 months; any missing initials of staff will be addressed immediately. The Dietary Director will audit the condition of the kitchen, equipment, or storage areas and address staff that initiated the cleaning logs if problems are noted. All problems with documentation as well as the cleanliness of the kitchen, equipment, or storage areas will be addressed immediately. 4 The Dietary Director or designee will in-service all dietary staff on facility schedules for daily, weekly, and monthly cleaning monthly for 6 months. 5 Systemic changes will be completed and in effect by February 3, 2025.	
R 0296 Bldg. 00	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance Based on interview and record review, the facility failed to ensure narcotic medications and narcotic cards were counted, during shift change, for 1 of 3 days reviewed for pharmacy services. (Medication Cart 1) Findings include: The November 2024 shift change controlled substance inventory count sheet (narcotic verification form) was reviewed on 1/15/25 at 11:15	R 0296	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	02/03/2025

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	a.m. The record lacked documentation of a signature of the off going nurse and the night shift oncoming nurse at the shift change on 11/13/24. The undated written statement from the Wellness Director (WD) indicated she had received a phone call from Licensed Practical Nurse (LPN) 6 on 11/13/24 at 7:07 p.m. The LPN indicated she was unable to locate a bottle of Morphine in Medication Cart 1. The WD asked LPN 6 if the count was correct when she received the keys and counted the carts with Qualified Medication Aide (QMA) 7. LPN 6 indicated she had not count the cart with QMA 7 when she arrived because she came in late and told QMA 7 to leave. The LPN contacted QMA 7 and she returned to the building to help locate the Morphine. At 7:20 p.m., the WD received a call back from LPN 6 and she indicated she still could not find the morphine. She received a call from QMA 7 at 7:47 p.m. who informed the WD of an incident that occurred between her (QMA 7) and LPN 6. Shortly after that, LPN 6 called her and reported she had found the morphine under the narcotic book. During an interview 1/15/25 at 9:28 a.m., the WD indicated on 11/13/24, she had received a phone call from LPN 6 about possible missing medications because LPN 6 could not find a bottle of Morphine. The medication in question was found prior to her arrival to the building. Once she had gotten to the facility, she requested the keys from LPN 6 to count the cart and then told LPN 6 she would be suspended pending an investigation. She asked LPN 6 which residents had received medications and LPN 6 refused to tell her until the WD finished counting to make sure the count was correct. The shift change controlled substance inventory count sheet was		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 296 1 The Wellness Director or designee will in-service all nurses/QMAs on facility policy for narcotics Controlled drugs by February 3, 2025. 2 The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. The Wellness Director or designee audited all narcotic counts and sign-off sheets by February 3, 2025 for the month of January 2025 noting any discrepancies.	

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	signed by the WD on 11/13/24 at 8:30 p.m. During an interview on 1/15/25 at 12:10 p.m., QMA 7 indicated on 11/13/24, she had looked at her watch and it was 6:15 p.m. and LPN 6 had not arrived. QMA 7 was outside when LPN 6 arrived. LPN 6 told QMA 7 to just go ahead and leave since she arrived late to work. LPN 6 could be very intimidating, so QMA 7 went ahead and left. She did not count the cart with LPN 6 prior to leaving and should have. The facility policy was to count the narcotics and the cards at the end of shift with the oncoming nurse. QMA 7 and LPN 6 never verified the controlled substances at the time of transferring the keys to the medication cart. The first time the controlled substances were verified was when the WD came into the facility two hours after shift change. On 1/16/25 at 9:05 a.m., the Wellness Director provided a current copy of the document titled "Narcotic/Controlled Drugs" dated 8/17. It included, but was not limited to, "It is the policy of the Community to ensure the proper handling and tracking of controlled medications...At each shift change, the narcotics count should verified by the oncoming and previous shift...The Shift-to-Shift Narcotic Count Verification form will be signed by both the outgoing and the on-coming designated Care Partners...." This Citation relates to Complaint IN00447297		3 The Wellness Director or designee will audit narcotic count sheets daily for 1 week, then 3 days a week for 4 weeks, then 2 times a week for 4 weeks, then once weekly for 4 weeks, then every other week for 4 weeks then monthly thereafter for 1 month. 4 The Wellness Director or designee will in-service all nurses/QMAs on facility policy for narcotic/ controlled drugs monthly times 6 months. 5 Systemic changes will be completed and in effect by February 3, 2025.	