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	06/11/2025

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 Complaint IN00460885. Complaint IN00460885 - State deficiencies related to the allegations are cited at R0243 and R0297. Survey dates: June 10 and 11, 2025 Facility number: 010885 Residential Census: 80 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 13, 2025.	R 0000		
R 0243 Bldg. 00	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency Based on interview and record review, the facility failed to ensure a resident's (Resident E) medication administration record reflected the Health Services for 1 of 3 residents reviewed for medication administration. Findings include: The clinical record for Resident E was reviewed on 6/10/25 at 4:22 p.m. The resident's diagnoses included, but were not limited to, insomnia, depression and dementia. The physician's order, dated 5/20/25, indicated the resident was to receive Trazodone (medication for insomnia) 50 mg (milligrams) at 8:00 p.m.	R 0243	1 The Community reviewed Resident E's active medication orders to confirm that Resident E's medication administration record (MAR) is correct. Resident E is now receiving all prescribed medication. The Community informed Resident E's physician regarding the missed medication doses. 2.The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3 The Wellness Director (WD) will in-service all QMAs and	06/27/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ricki Elston	Executive Director	06/25/2025

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	The June 2025 medication administration record lacked documentation of the administration of the resident's Trazodone on 6/8/25 at 8:00 p.m. The physician's order, dated 5/2/25, indicated the resident was to receive Donepezil HCl (hydrochloride) 10 mg twice daily for dementia at 8:00 a.m. and 8:00 p.m. The June 2025 medication administration record lacked documentation of the administration of the resident's Donepezil on 6/8/25 at 8:00 p.m. The physician's order, dated 6/3/25, indicated the resident was to receive Quetiapine (medication used for depression) 12.5 mg twice daily at 8:00 a.m. and 8:00 p.m. The June 2025 medication administration record lacked documentation of the administration of the resident's Quetiapine on 6/8/25 at 8:00 p.m. During an interview, on 6/11/25 at 11:15 a.m., Licensed Practical Nurse (LPN) 5 indicated after a medication was administered, the medication should be signed out on the medication administration record to show the medication was administered. On 6/11/25 at 1:12 p.m., the Executive Director provided a copy of the document titled "Community Team Members Procedures For Medication Assistance" dated 8/17. It included, but was not limited to, "Initial in the appropriate space on the Resident's Medication Administration Record (MAR)...for that day and time (also Community Team Members must sign the MAR...)...." This Citation relates to Complaint IN00460885		Nurses on “Common Medication Errors” by 6/27/25 to educate and ensure that the deficient practice does not recur. 4 To ensure the deficient practices do not recur the WD or designee is to audit the Missed Medications noted under Missed Medications Tab in August Health (EMAR system) daily x1 week, then 3 times a week x 4 weeks, then 2 times a week x 4 weeks, then weekly x 4 weeks, then monthly for 1 month. 5 Systemic changes will be completed by 6/27/25.	

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R 0297 Bldg. 00	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance Based on interview and record review, the facility failed to ensure a resident's (Resident B) medications were available to administer for 1 of 3 residents reviewed for pharmacy services. Findings include: The clinical record for Resident B was reviewed on 6/10/25 at 3:10 p.m. The resident's diagnoses included, but were not limited to, dementia and unspecified male sexual dysfunction. The physician's order, dated 3/18/25, indicated the resident was to have an Estradiol 0.1 mg (milligram) transdermal patch topically every week on Wednesday. Review of the April 2025 medication administration record indicated the resident did not receive the Estradiol transdermal patch due to not available. The clinical record lacked documentation of the physician and pharmacy notification related to the unavailability of the resident's Estradiol transdermal patch. During an interview, on 6/11/25 at 1:22 p.m., the Executive Director indicated the facility was responsible to ensure the residents medications were available. On 6/11/25 at 1:05 p.m., the Executive Director provided a portion of the pharmacy services policy, requested on 6/11/25 at 12:50 p.m., and dated 8/17. It included, but was not limited to, "If the medication had not arrived from the pharmacy	R 0297	1. The Community reviewed Resident B's active medication orders to confirm that Resident E's MAR is correct. Resident B is now receiving all prescribed medication. The Community informed Resident B's physician regarding the missed medication doses. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. The WD will complete 1-on-1 in-service/coachable moments with each QMA/Nurse for the unavailable medication process. This will be completed by 6/27/25. 3. To ensure the deficient practices do not recur, the WD or designee is to audit the Unavailable Medications noted under Unavailable Medications Tab in August Health (EMAR system) daily x1 week, then 3 times a week x 4 weeks, then 2 times a week x 4 weeks, then weekly x 4 weeks, then monthly for 1 month. 4. Systemic changes will be completed by 6/27/25.	06/27/2025

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	as scheduled, follow up should be made every shift by phone call to the pharmacy to find status...." This Citation relates to Complaint IN00460885			