

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER <b>155621</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>03/01/2024</b>
NAME OF PROVIDER OR SUPPLIER <b>RIVER BEND NURSING AND REHABILITATION</b>		STREET ADDRESS, CITY, STATE, ZIP COD <b>3400 STOCKER DR EVANSVILLE, IN 47720</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	<p>This visit was for the Investigation of Complaint IN00429533, IN00428768, and IN00428560.</p> <p>Complaint IN00429533- Federal/state deficiencies related to the allegations are cited at F600.</p> <p>Complaint IN00428768- Federal/state deficiencies related to the allegations are cited at F600.</p> <p>Complaint IN00428560- Federal/state deficiencies related to the allegations are cited at F600.</p> <p>Survey dates: February 29, March 1, 2024.</p> <p>Facility number: 000442 Provider number: 155621 AIM number: 100266510</p> <p>Census Bed Type: SNF/NF: 62 Total: 62</p> <p>Census Payor Type: Medicare: 4 Medicaid: 53 Other: 5 Total: 62</p> <p>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on March 7, 2024.</p>	F 0000	<p>By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations by the ISDH. 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 requests that the Plan of Correction (POC) be considered our allegation of compliance, effective March 22nd 2024. Facility is respectfully requesting a desk review.</p>	
F 0600  SS=D  Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER <b>155621</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>03/01/2024</b>
NAME OF PROVIDER OR SUPPLIER <b>RIVER BEND NURSING AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP COD <b>3400 STOCKER DR EVANSVILLE, IN 47720</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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)
	<p>The resident has the right to be free from 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.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were free of abuse for 1 of 3 residents reviewed for abuse. A resident was inappropriately touched by another resident. ( Resident D, Resident E)</p> <p>Finding includes:</p> <p>On 2/29/24 at 9:50 a.m., the DON indicated the facility had one state reportable that police were involved in. She had received a phone call reporting that Resident D had been observed by a staff member inappropriately touching Resident E.</p> <p>At 10:30 a.m. a state reportable was reviewed and included, but was not limited to:</p> <p>Incident date : 2/8/2024 at 6:20 p.m.</p> <p>Description added: Resident [name (Resident D)] was noted to touch resident [name (Resident E)] inappropriately.</p> <p>Type of injury added: 2/8/2024 Residents immediately separated, MD's, families, and police</p>		F 0600	<p><b>What corrective actions will be accomplished for those residents found to have been affected by the</b></p> <p>Residents D and E were immediately separated by the nursing staff to ensure safety.</p> <p>The physicians, responsible parties, Administrator, DON, SSD, and police were immediately notified on 2/8/24.</p> <p>Licensed nurse completed head to toe assessment on Resident D and E on 2/8/2024 with no new findings.</p> <p>Resident D was moved to another room and floor within the facility, immediately placed on 1:1 staff supervision and remained on 1:1 until he was transferred to a local in-patient psych facility.</p> <p>Resident E was assessed for psychosocial distress and provided with psychosocial support from the facility Social Services Director. Resident denied</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER <b>155621</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>03/01/2024</b>	
NAME OF PROVIDER OR SUPPLIER <b>RIVER BEND NURSING AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP COD <b>3400 STOCKER DR EVANSVILLE, IN 47720</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>notified of incident. Resident [name(Resident D)] immediately placed on 1 to 1 supervision.</p> <p>Follow up: 2/14/2024 Resident [name(Resident D)] continues to be on 1 to 1 supervision. Police made aware of the incident with a case number provided. MD and family notified of both residents. APS (Adult Protective Services) involved with the care of resident [name(Resident D)] and are in the process of obtaining a court appointed guardian. Referrals for a psych stay have been made for [name], awaiting bed opening. APS has given approval for transfer if needed. Both residents have been interviewed and neither can recall the incident. Psychosocial support has been provided to both residents and neither show any signs of changes in mood. Resident [name(Resident D)] was seen by psych services with notes stating he has some moderate anxiety, with a diagnosis of anxiety disorder, has limited recollection of the incident and has no desire to discuss the incident. Resident [name] was relocated to an alternate unit. Skin assessments were completed on [name] and all residents residing on the unit with no findings. Resident interviews completed on all alert and oriented residents with no findings. Psychosocial support continues for both residents, psych services as ordered. 1 to 1 supervision for [name(Resident D)] will be provided until psych stay can be secured.</p> <p>A witness statement by CNA 1 was reviewed and included the following: " 2/9/24 [name(Resident E)] was sitting in lobby in front of tv. [name(Resident D)] was sitting next [name(Resident E)] " I saw [name(Resident D)] hand down [name(Resident E)] pants" [name(Resident E)] had non verbal statements to stop but he looked upset. " I immediately told [name(Resident D)] to stop and he said " God</p>			<p>having any memory recall of event during the daily interviews conducted by the SSD.</p> <p>The SSD reviewed updated Resident E's SS assessment that included past trauma section on 2/9/24.</p> <p>Licensed nursing staff/designee has updated Resident D and E's plan of care.</p> <p><b>How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</b></p> <p>Other residents who have experienced sexual trauma have the potential to be affected.</p> <p>SS/designee will complete an audit of current residents to identify those who have experienced past sexual abuse/trauma. An individual plan of care implemented per review and discussion with the physician, IDT, res and/or responsible parties to ensure appropriate safety measures and interventions in place to address psychosocial needs r/t to the past sexual trauma.</p> <p>SS/designee will complete a Trauma Assessment on newly admitted residents to identify past sexual trauma. Residents identified as having past sexual abuse/trauma will have an individual plan of care implemented per review and</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER <b>155621</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>03/01/2024</b>
NAME OF PROVIDER OR SUPPLIER <b>RIVER BEND NURSING AND REHABILITATION</b>		STREET ADDRESS, CITY, STATE, ZIP COD <b>3400 STOCKER DR EVANSVILLE, IN 47720</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Dammit he liked it"</p> <p>Per phone interview with CNA 1 [name].</p> <p>On 2/29/24 at 11:20 a.m., Resident E was observed lying in his bed in his room. Resident E indicated he had not been inappropriately touched by another resident or anyone at the facility, he did not feel afraid or unsafe.</p> <p>On 2/29/24 at 11:30 a.m., Resident E's clinical record was reviewed. Diagnoses included, but were not limited to, bipolar disorder, major depressive disorder, recurrent, moderate, Parkinson's disease, generalized anxiety disorder, unspecified dementia, unspecified severity, with mood mood disturbance, psychotic disorder with delusions due to known physiological condition. A significant change MDS (Minimum Data Set) assessment dated 1/15/24, indicated Resident E's cognition was moderately impaired.</p> <p>Care plans were reviewed and included, but were not limited to:</p> <p>[name(Resident E)] has a history of traumatic event and may experience stress related to the event, date initiated 2/9/2024.</p> <p>Progress notes were reviewed and included the following:</p> <p>2/8/24 at 6:30 p.m., " Staff alerted this nurse that resident in room 201 had his hand down another resident's pants. Upon assessment resident in room 208 B reported that resident in 211 had his hand down his pants touching his penis. Resident stated, " That guy rubbed my stomach and (sic) then put his hand down my pants. He was holding my penis." Head to toe assessment completed with no abnormalities noted, resident in 211 taken back to room and placed on 1 on 1, DON notified,</p>		<p>discussion with the physician, IDT, res and/or responsible parties to ensure appropriate safety measures and interventions in place to address psychosocial needs r/t to the past sexual trauma.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <p>SS/designee will provide education to licensed and certified nursing associates on the prevention and management of residents who have experienced sexual abuse trauma.</p> <p>The DON/designee to provide education to the SSD on requirements to complete the trauma assessment, individual plan of care to be implemented per review and discussion with the physician, IDT, res and/or responsible parties to ensure appropriate safety measures and interventions in place to address psychosocial needs r/t to the past sexual trauma.</p> <p>The facility has implemented a new, more detailed electronic Trauma Assessment that meets the state and federal guidelines. An individual plan of care will be implemented based on each resident's personal past sexual trauma.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER <b>155621</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>03/01/2024</b>
NAME OF PROVIDER OR SUPPLIER <b>RIVER BEND NURSING AND REHABILITATION</b>		STREET ADDRESS, CITY, STATE, ZIP COD <b>3400 STOCKER DR EVANSVILLE, IN 47720</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>911 called and report given, NHT (nursing home triage) notified, Hospice notified, and resident emergency contact notified."</p> <p>A psychotherapy progress note dated 2/9/2024 included, but was not limited to:</p> <p>Subjective interval history and coordination of care ..." It is reported by facility that pt reported being touched inappropriately by another resident on or about 2/8/24. Law enforcement was contacted. The reported perp was moved to 1st floor. Pt reports feelings of trauma from childhood sexual abuse were triggered by incident. Pt's anxiety is reportedly being treated with medication."</p> <p>Summary of Session ....Therapist asked about the incident from 2-8-24 (see interval hx). Pt denies any stress and reports no desire to talk about any incident..."</p> <p>Resident E's EMAR (Electronic Medication Administration Record) was reviewed for February 2024 and included the following: Lorazepam (anti-anxiety ) tablet 0.5 mg(milligram) by mouth every 2 hours as needed for anxiety, start date 1/12/24.</p> <p>Given on the following dates and times:</p> <p>2/9/24- 7:30 p.m. 2/11/24- 7:40 p.m. 2/12/24- 10:15 p.m. 2/18/24- 7:30 p.m., 10:29 p.m. 2/22/24- 7:30 p.m. 2/24/24- 7:44 p.m. 2/25/24- 11:50 p.m. 2/26/24- 6:39 p.m. 2/27/24- 7:00 p.m. 2/29/24- 7:40 p.m.</p>		<p><b>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p>The DON/designee will audit newly admitted residents' medical record to ensure that the SS/trauma assessment has been completed and that any reports of past sexual trauma has been appropriately addressed as per state and federal guidelines and that an individual plan of care is in place to ensure their safety and psychosocial well-being. Auditing to occur 4 new admits if they occur wkly x's 4 wks, 4 new admits monthly if they occur x's 5 months for a total of 6 months of monitoring.</p> <p>The DON/designee will also complete a medical record audit post any residents with new report of sexual trauma has had an updated Trauma assessment and that measures are in place to appropriately addressed as per state and federal guidelines and that an individual plan of care is in place to ensure their safety and psychosocial well-being. Auditing to occur with any new report of sexual trauma x's 6 months of monitoring. Any findings will be addressed.</p> <p>The results of these reviews will be discussed at the monthly facility Quality Assurance</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER <b>155621</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>03/01/2024</b>
NAME OF PROVIDER OR SUPPLIER <b>RIVER BEND NURSING AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP COD <b>3400 STOCKER DR EVANSVILLE, IN 47720</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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)
	<p>On 2/29/24 at 11:41 a.m., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, altered mental status unspecified, dementia in other diseases classified elsewhere, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. An admission MDS (Minimum Date Set) assessment dated 2/1/24, indicated Resident D's cognition was moderately impaired.</p> <p>Care plans were reviewed and included, but were not limited to:</p> <p>[name(Resident D)] demonstrates inappropriate sexual behavior at times mental/emotional illness. [name] will take gown off and refuse to keep clothes on. [name(Resident D)] will walk out into hallway with no clothes on, date initiated 2/9/24.</p> <p>Progress notes were reviewed and included, but were not limited to:</p> <p>2/8/24 at 6:15 p.m., " "Staff reported that resident had his hand down another resident's pant's, upon assessment, resident was leaving lounge area. This nurse inquired what had happened and resident stated, "Oh, he liked it, I didn't do a damn thing wrong." This resident immediately placed 1 on 1 and safety provided to other resident involved. Statements received, DON notified, and 911 called/report given,"</p> <p>On 3/1/24 at 1:29 p.m., the Infection Preventionist Nurse provided the current abuse policy with a revised date of 11/28/16. The policy included, but was not limited to: The resident has the right to be free from 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</p>			<p>Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring.</p> <p>Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance exist.</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER <b>155621</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>03/01/2024</b>
NAME OF PROVIDER OR SUPPLIER <b>RIVER BEND NURSING AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP COD <b>3400 STOCKER DR EVANSVILLE, IN 47720</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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)
	<p>not required to treat the resident's medical symptoms. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion...Residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants, or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals...</p> <p>This citation relates to Complaint IN00429533, IN00428768, and IN00428560.</p> <p>3.1-27(a)(1)</p>			