

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155621	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER RIVER BEND NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP COD 3400 STOCKER DR EVANSVILLE, IN 47720		
(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 IN00434734.</p> <p>Complaint IN00434734- Federal/state deficiencies related to the allegations are cited at F755.</p> <p>Survey dates: June 4, 5, 2024.</p> <p>Facility number: 000442 Provider number: 155621 AIM number: 100266510</p> <p>Census Bed Type: SNF: 8 SNF/NF: 57 Total: 65</p> <p>Census Payor Type: Medicare: 5 Medicaid: 42 Other: 18 Total: 65</p> <p>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on June 12, 2024.</p>	F 0000		
F 0755 SS=E Bldg. 00	<p>483.45(a)(b)(1)-(3)</p> <p>Pharmacy</p> <p>Srvcs/Procedures/Pharmacist/Records</p> <p>Based on observation, record review, and interview, the facility failed to ensure medications were disposed of in a timely manner for discharged residents, medications that had been discontinued were disposed of, controlled medications were double locked, refrigerator</p>	F 0755	<p>F 755 Pharmacy Services</p> <p>What corrective action will be accomplished for those residents found to have been affected by the alleged deficit practice.</p> <p>Padlock on medication refrigerator</p>	07/05/2024

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155621	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER RIVER BEND NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP COD 3400 STOCKER DR EVANSVILLE, IN 47720		
(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>temperature logs in place, ice removal in refrigerator freezer, a system was in place for documentation of medication disposition, for 2 of 2 medication rooms observed, and 5 of 5 residents reviewed for medications. (Resident D, Resident E, Resident G, Resident H, Resident J, Stocker unit medication room, North/South unit medication room)</p> <p>Findings include:</p> <p>On 6/4/24 at 8:29 a.m., an observation of the Stocker unit medication room was done. The following was observed:</p> <ol style="list-style-type: none"> 1. The refrigerator containing, but not limited to controlled medications, was observed to have a padlock that was not locked. 2. The refrigerator freezer was observed to have a thick layer of ice with unidentifiable medication packages stuck in the ice. 3. An EDK (emergency drug kit) box in the refrigerator that contained 1 bottle of lorazepam intensol 2 mg (milligram) per ml (milliliter), two vials of lorazepam 2 mg/ml. 4. One bottle of lorazepam intensol 2 mg/ml for Resident H in the refrigerator. Resident H's medication had been discontinued on 10/24/23. 5. One bottle of lorazepam intensol 2 mg/ml for Resident Resident G in the refrigerator. 6. A clear plastic cup containing a bottle of lorazepam intensol 2 mg/ml with no resident 		<p>was replaced during survey. The refrigerator/freezer was thawed, and no medication was in the freezer. (ice packs were). All medications in the refrigerator were reconciled with orders and if appropriate disposed of properly. Pharmacy has audited all medication carts and medication rooms for expired and discharged or discontinued medications and disposed of properly. Resident D,E, G, H, and J medications noted in the 2567 were stored or disposed of properly.</p> <p>How other residents having the potential to be affected by the same alleged deficit practice will be identified and what corrective action will be taken.</p> <p>All residents that have medication have the potential to be affected by the alleged deficit practice. What measures will be put in place and what systemic change will be made to ensure that the deficit practice does not recur.</p> <p>Education provided to nursing staff on proper medication disposition tracking and documentation.</p> <p>Education provided to nursing staff on proper medication storage and temperature monitoring in medication refrigerator. Education provided on proper double lock requirement for controlled medications in the refrigerator.</p> <p>Education included disposition process for all medications including proper return or disposal</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155621	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER RIVER BEND NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP COD 3400 STOCKER DR EVANSVILLE, IN 47720	
(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>identifier on the bottle in the refrigerator. The cup had Resident E's name written on it in black marker. Resident E expired at the facility on 5/1/24.</p> <p>7. A tote on the floor contained a bottle of sulfacetamide 10% eye drops, container of polyethylen glycol for Resident D. Resident D had expired at the facility on 5/20/24.</p> <p>8. A bottle of ocean spray 0.65 % for Resident J. Resident J was discharged from the facility on 4/23/24.</p> <p>8. The refrigerator did not have a temperature log sheet.</p> <p>9. On 6/4/24 at 9:00 a.m., an observation of the North/South unit medication room was done. The refrigerator freezer had ice build up.</p> <p>On 6/5/24 at 8:13 a.m., RN 1 indicated non narcotic medications are collected and put into a tote after a resident is discharged from the facility, usually night shift will take it downstairs to the main medication room for pharmacy to pick up. RN 1 indicated documentation of drug disposition was not being done on non narcotic medications, they were just put in a tote for pharmacy to pick up.</p> <p>On 6/5/24 at 8:16 a.m., the DON indicated the facility procedure for drug disposition for non controlled medications had been to put them on the counter or in a cardboard box in the medication room to return to pharmacy, documenting for drug disposition was not being done. The pharmacy had told the facility forms were not required for disposition as they were doing the disposition. The DON indicated she had implemented that disposition forms are now to be</p>		<p>of medications at discharge. Two new medication refrigerators purchased that have proper locks for medications required to be double locked. No freezers will be in the new refrigerators.</p> <p>How the corrective action will be monitored to ensure the deficit practice will not recur, i.e., what quality assurance program will be put in place.</p> <p>DON/designee will audit medication refrigerator double locks and temperature logs 5 times a week for 2 weeks, weekly for 4 weeks and monthly for 3 months. Audit outcome will be reported to QAPI monthly and reviewed quarterly for compliance.</p> <p>An action plan will be developed for non-compliance concerns as determined by QAPI.</p> <p>DON/designee will audit disposition status of discharged residents and discontinued medications 5 times a week for 2 weeks, weekly for 4 weeks and monthly for 3 months. Audit outcome will be reported to QAPI monthly and reviewed for compliance.</p> <p>The results of these audits will be discussed at the facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and duration</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 155621	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER RIVER BEND NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP COD 3400 STOCKER DR EVANSVILLE, IN 47720		
(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>filled out for medications.</p> <p>On 6/5/24 at 1:44 p.m., the Administrator provided the current pharmacy policy and procedure with a reviewed date of 5/20/20. The policy included, but was not limited to: In accordance with State and Federal laws, manufacturer recommendations or supplier recommendations, the facility must store all medications and biologicals in locked compartments or storage rooms under proper temperature controls...2. The facility is required to secure all medications in a locked storage area and to limit access to only authorized or licensed personnel consistent with state or federal requirements and professional standards of practice. a. storage areas may include, but are not limited to, drawers, cabinets, medication rooms, refrigerators, and carts. b. access to medication(s) may be controlled by keys, security codes or cards, or other technology such as fingerprints...9. controlled medication(s), narcotics, are stored separately from other medications in a locked drawer or compartment designated for that purpose...11. medications(s) requiring storage in a refrigerator are kept at temperatures maintained between ...36 and 46 F)...21. Disposal of medications(s) should be completed for medication(s) that are without secure closure, outdated, contaminated, or deteriorated. a. disposal needs to be timely . b. removed medication(s) immediately from stock...e. document disposal of medication(s) i. include resident name, medication name, strength, prescription number as applicable, quantity, date of disposal, involved personnel, and method of disposal...23. medication storage area conditions are monitored on a monthly basis and corrective action taken if problems identified...</p> <p>This citation relates to Complaint IN00434734.</p>		<p>of auditing will be increased as needed, if areas of noncompliance are identified through the auditing process.</p> <p>Date completed: July 5, 2024.</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 155621	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER RIVER BEND NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP COD 3400 STOCKER DR EVANSVILLE, IN 47720	
(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)
	3.1-25(m) 3.1-25(o) 3.1-25(s)			