PRINTED: 01/23/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
			B. WI	NG		12/18/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					HARLESTOWN PIKE		
RIVERBEND			JEFFERSONVILLE, IN 47130				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
R 0000							
Bldg. 00							
Diag. 00	This visit was for the Investigation of Complaint IN00422665. Complaint IN00422665 - State deficiencies related to the allegations are cited at R0052 and R0053.		R 0000				
	Survey date: Decen	nber 18, 2023					
	Facility number: 010885						
	Residential Census: 89						
These State Residential Findings a accordance with 410 IAC 16.2-5.		_					
	Quality review completed on December 21, 2023.						
R 0052	410 IAC 16.2-5-1.2	, , , ,					
Bldg. 00	Residents' Rights - Offense (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 observation, interview and record review, the facility failed to ensure staff to resident physical abuse did not occur for 1 of 3 residents reviewed for abuse. (Resident B)						
			R 0052		This plan of correction is submitted as required under S and Federal law. The submiss of this Plan of Correction does constitute an admission on the	sion s not	01/02/2024
	on 12/18/23 at 10:18	for Resident B was reviewed 8 a.m. The diagnoses included, I to, dementia, anxiety and		part of Riverbendas to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the		Plan	

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

TITLE (X6) DATE

Ricki Elston Executive Director 01/15/2024

Any defiency statement 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 disclodays 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.

State Form Event ID: TY3B11 Facility ID: 010885 If continuation sheet Page 1 of 6

PRINTED: 01/23/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	OO OOSTRUCTION	(X3) DATE SURVEY COMPLETED 12/18/2023				
NAME OF I	PROVIDER OR SUPPLIE			ADDRESS, CITY, STATE, ZIP COD				
RIVERBEND			2715 CHARLESTOWN PIKE JEFFERSONVILLE, IN 47130					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED OF THE APPROPRIED	BE COMPLETION			
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	+	DATE			
	During an observat	tion on 12/18/23 at 10:07 a.m.,		findings constitute a deficie that the scope and severity	-			
	_	ting in the dining room with		regarding the deficiency cite				
	other residents. He	had no signs of bruising.		correctly applied. Any chan				
				the Community's policies a	nd			
		dent report, dated 11/23/23 at		procedures should be cons				
		d CNA (Certified Nursing Aide)		subsequent remedial meas	I			
	,	CNA 4 and CNA 5 to curse at the bathroom to the common		that concept is employed in				
		CNA 3 pulled Resident B up in		407 of the Federal Rules of Evidence and any corresponding				
	the chair.	CIVA 5 puncu Resident B up in		state rules of civil procedure	-			
	the chair.			should be inadmissible in a	I			
	On 12/18/23 at 9:5	8 a.m., the Wellness Director		proceeding on that basis. T	-			
	indicated she received an early morning call on			Community submits this pla				
	11/23/23 from QM	A (Qualified Medication Aide)		correction with the intention	that it			
	10 and reported CNA 3 walked off the job after			be inadmissible by any third	d party			
	she had screamed at Resident B. She went to the			in any civil or criminal action	I			
	facility and assessed Resident B and all the			against the Community or a	-			
	residents on the Memory Care unit.			employee, agent, officer, di	I			
	During an interview	w on 12/18/23 at 10:34 a.m.,		attorney, or shareholder of Community or affiliated	ine			
	_	he and CNA 5 were seated in		companies.				
		esident B often gets up to		TAG 052				
	_	steady on his feet. CNA 3		Nurse completed head-to-	-toe			
	grabbed Resident I	B by the waist and pushed him		skin assessments on all res	sidents			
		n the common area to get him to		in memory care that were				
		B was seated on the edge of		assigned to CNA in questio				
		A 3 went behind him, pulled		including Resident B, with r				
	•	ack forcefully and said		bruising or other signs of al				
		nt B's name)" and aggressively to sit still, you are too		found. Resident B was mor				
		eet." CNA 4 went over to		for 72 hours for any psycho distress with none noted. R				
		he realized what had happened.		B's family and physician we				
		dining room and said "I hate		notified. CNA in question is	I			
	this g*dd**n place	_		longer employed by Comm	I			
				The Community reviewed e	-			
		16 a.m., CNA 5 indicated on the		resident's record to determine				
	_	nt, she observed CNA 3 take		which residents, if any, cou				
		pathroom. On the way back to		affected by the alleged defi	I			
	the common area, (CNA 3 appeared to be		practice. • Abuse in-service				

State Form Event ID: TY3B11 Facility ID: 010885 If continuation sheet Page 2 of 6

PRINTED: 01/23/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED		
			B. WING		12/18/2023			
			CT	DEET A	DDDECC CITY CTATE ZID COD			
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD			
RIVERBEND			2715 CHARLESTOWN PIKE					
RIVERDE	באט		J		RSONVILLE, IN 47130			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II)	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TA	AG	DEFICIENCY)		DATE	
	aggressive with Res	sident B. CNA 3 was holding			completed with all staff on			
	Resident B by the waist when he stumbled and				11/26/23. Residents Rights			
	CNA 3 said "come	on (Resident B's name), I don't			in-service completed with all s	taff		
		ght". Resident B fell into the			on 11/27/23. Abuse and Resid			
		id "g*dd**it (Resident B's			Rights in-services to be compl			
		hind the chair, pulled him up			by Wellness Director or design			
		ed him towards the back of the			monthly for 3 months, then eve			
		, you do not do anyone like			other month for 3 months. •			
		ready headed over to Resident			Weekly for two months the			
		A 3 walked to the dining room			Wellness Director or designee	will		
	and said "f**k this	place." CNA 5 then went			(i) conduct interviews with thre			
	outside to report wh	nat had just happened to QMA			care staff members (one from			
	10. CNA 5 and QM	A 10 came into the facility and			each shift) and two interview-a	ıble		
	met CNA 3 on their	way in. CNA 3 looked and			memory care residents and (ii)			
	said "I did not do ar	nything wrong, I quit and you	review shower logs for indications					
	do you."				of physical abuse for six memo			
	ac year				care residents. If any indication	-		
	On 12/18/23 at 9:40 a.m., the Wellness Director				of abuse are found, said interv			
	provided a current of	copy of the document titled			and shower logs reviews will			
	"Abuse Prevention	Policy" dated 8/10/18. It			continue weekly for another tw	1 0		
		ot limited to, "PolicyIt is the			months and additional staff			
		y to protect residents from			training will be conducted.			
		ulA willful act is one the			Additionally, any occurrence w	/ill		
	individual intended	and one that the individual			be reported and addressed pe			
		e known could cause physical			Community's Abuse policy. If r			
		al anguishPhysical			indications of abuse are found			
	_	ut is not limited tocontrolling			during a two month period, the			
		buseRefers to the use of			heightened monitoring will stop			
		willfully includesderogatory			Systemic changes will be			
	~ ~	or within their hearing			completed and in effect 1/14/2	4.		
		of their age, ability to			p			
	comprehend"	<i>5</i> / ,						
	•							
	This Citation relates	s to Complaint IN00422665						
		•						
R 0053	410 IAC 16.2-5-1.	2(w)		j				
	Residents' Rights	- Deficiency						
Bldg. 00		e the right to be free from						
	verbal abuse.	-						
	Based on observation	on, interview and record	R 0053	j	This plan of correction is		01/02/2024	

State Form Event ID: TY3B11 Facility ID: 010885 If continuation sheet Page 3 of 6

PRINTED: 01/23/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		B. WING			12/18/2023		
	CTREET LIBRIDGE CVTV CT LTE (III) COD						
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
				2715 CHARLESTOWN PIKE			
RIVERBEND				JEFFERSONVILLE, IN 47130			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVINED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	T.C.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	review, the facility failed to ensure staff to				submitted as required under S	tate	
	resident verbal abu	se did not occur for 1 of 3			and Federal law. The submiss		
	residents reviewed	for abuse. (Resident B)			of this Plan of Correction does		
		,			constitute an admission on the	;	
	Findings include:				part of Riverbendas to the		
					accuracy of the surveyors' find	linas	
	The clinical record	for Resident B was reviewed			or the conclusions drawn	3	
	on 12/18/23 at 10:1	8 a.m. The diagnoses included,			therefrom. Submission of this	Plan	
		d to, dementia, anxiety and			of Correction also does not		
	sleep disorder.	•			constitute an admission that th	ne	
					findings constitute a deficiency		
	On 12/18/23 at 12::	56 p.m., Resident B was			that the scope and severity		
		ed. A staff member was			regarding the deficiency cited	are	
		nt with a blanket and the			correctly applied. Any changes		
	resident showed not signs of any psychosocial				the Community's policies and		
	distress.				procedures should be conside	red	
					subsequent remedial measure		
	The incident report	, dated 11/23/23 at 4:01 a.m.,			that concept is employed in Ru		
	_	rtified Nursing Assistant) 3			407 of the Federal Rules of		
		NA 4 and CNA 5 to curse at			Evidence and any correspondi	ing	
		e bathroom to the common			state rules of civil procedure a	-	
	area. Once seated,	CNA 3 pulled Resident B up in			should be inadmissible in any		
	the chair.				proceeding on that basis. The		
					Community submits this plan of	of	
	During an interview	v on 12/18/23 at 9:58 a.m., the			correction with the intention the		
	Wellness Director i	ndicated she received an early			be inadmissible by any third pa	arty	
	morning call on 11	23/23 from QMA (Qualified			in any civil or criminal action	•	
	Medication Aide) 1	0 and reported CNA 3 walked			against the Community or any		
	· ·	had screamed at Resident B.			employee, agent, officer, direc		
	She went to the fac	ility and assessed Resident B			attorney, or shareholder of the		
	and all the resident	s on the Memory Care unit.			Community or affiliated		
					companies.		
	During an interview	v on 12/18/23 at 10:34 a.m.,			TAG 053		
		ne and CNA 5 were seated in			Nurse completed head-to-toe	,	
	the dining room. Re	esident B often gets up to			skin assessments on all reside		
		steady on his feet. When CNA			in memory care that were		
		the resident back in his chair,			assigned to CNA in question,		
		d**it (Resident B's name)" and			including Resident B, with no		
		you have got to sit still, you			bruising or other signs of abus	е	
	are too unsteady on your feet." CNA 4 went over				found. Resident B was monito		

State Form Event ID: TY3B11 Facility ID: 010885 If continuation sheet Page 4 of 6

PRINTED: 01/23/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED		
			B. WING 12/18/202			2023		
			<u> </u>	CTDEET A	ADDRESS CITY STATE ZIR COD			
NAME OF P	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD			
RIVERBEND				2715 CHARLESTOWN PIKE				
KIVEKBE				JETTER	RSONVILLE, IN 47130			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	to Resident B when she realized what had				for 72 hours for any psychoso	cial		
		vent to the dining room and			distress with none noted.			
	said "I hate this g*c	ld**n place."			Resident's family and physicia	esident's family and physician		
					were notified. CNA in question	· .		
	_	on 12/18/23 at 11:16 a.m.,			no longer employed by			
	CNA 5 indicated th	e night of the incident, she			Community. • The Community			
		ke Resident B to the bathroom.			reviewed each resident's reco	rd to		
	I	the common area, CNA 3			determine which residents, if a	any,		
	1	essive with Resident B. CNA			could be affected by the allege	ed		
	_	dent B by the waist when he			deficient practice. • Abuse			
		3 said "come on (Resident B's			in-service completed with all s	taff		
	name), I don't have	all f**king night". Resident B			on 11/26/23. Residents Rights	;		
	fell into the chair ar	nd CNA 3 said "g*dd**it			in-service completed with all s	taff		
	(Resident B's name)", then got behind the chair,			on 11/27/23. Abuse and Resid	lent		
	pulled him up force	fully and yanked him towards			Rights in-services to be compl	eted		
		r. "It was abuse, you do not			by Wellness Director or desigr			
	do anyone like that'	'. CNA 4 had already headed			monthly for 3 months, then ev	ery		
		to intervene. CNA 3 walked to			other month for 3 months. •			
	the dining room and	l said "f**k this place." CNA 5			Weekly for two months the			
		report what had just			Wellness Director or designee	will		
		10. CNA 5 and QMA 10 came			conduct interviews with three	care		
	1	met CNA 3 on their way in.			staff members (one from each			
		said "I did not do anything			shift) and two interviewable			
	wrong, I quit and yo	ou do you."			memory care residents for			
					indications of verbal abuse. If	any		
		a.m., the Wellness Director			indications of abuse are found	,		
	_	copy of the document titled			said interviews will continue			
		Policy" dated 8/10/18. It			weekly for another two months			
		ot limited to, "PolicyIt is the			and additional staff training wi	ll be		
		y to protect residents from			conducted. Additionally, any			
		ulA willful act is one the			occurrence will be reported an			
	individual intended and one that the individual				addressed per the Community			
		e known could cause physical			Abuse policy. If no indications	of		
		al anguishPhysical			abuse are found during a			
		ut is not limited tocontrolling			two-month period, the heighte	ned		
		buseRefers to the use of			monitoring will stop. • Systemi	С		
	orallanguage that	willfully includesderogatory			changes will be completed and	d in		
	terms to residents	or within their hearing			effect 1/14/24			
	distance, regardless	of their age, ability to						
	comprehend"							

State Form Event ID: TY3B11 Facility ID: 010885 If continuation sheet Page 5 of 6

PRINTED: 01/23/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/18/2023		
NAME OF PROVIDER OR SUPPLIER RIVERBEND			STREET ADDRESS, CITY, STATE, ZIP COD 2715 CHARLESTOWN PIKE JEFFERSONVILLE, IN 47130				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
	This Citation relates	s to Complaint IN00422665					

State Form Event ID: TY3B11 Facility ID: 010885 If continuation sheet Page 6 of 6