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	12/18/2023

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 IN00422665. Complaint IN00422665 - State deficiencies related to the allegations are cited at R0052 and R0053. Survey date: December 18, 2023 Facility number: 010885 Residential Census: 89 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 21, 2023.	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) 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) Findings include: The clinical record for Resident B was reviewed on 12/18/23 at 10:18 a.m. The diagnoses included, but were not limited to, dementia, anxiety and sleep disorder.	R 0052	This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the 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	01/02/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ricki Elston	Executive Director	01/15/2024

Any defiencystatement 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 disclo 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.

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	During an observation on 12/18/23 at 10:07 a.m., Resident B was sitting in the dining room with other residents. He had no signs of bruising. Review of the incident report, dated 11/23/23 at 4:01 a.m., indicated CNA (Certified Nursing Aide) 3 was observed by CNA 4 and CNA 5 to curse at Resident B from the bathroom to the common area. Once seated, CNA 3 pulled Resident B up in the chair. On 12/18/23 at 9:58 a.m., the Wellness Director indicated she received an early morning call on 11/23/23 from QMA (Qualified Medication Aide) 10 and reported CNA 3 walked off the job after she had screamed at Resident B. She went to the facility and assessed Resident B and all the residents on the Memory Care unit. During an interview on 12/18/23 at 10:34 a.m., CNA 4 indicated she and CNA 5 were seated in the dining room. Resident B often gets up to urinate and was unsteady on his feet. CNA 3 grabbed Resident B by the waist and pushed him towards the chair in the common area to get him to sit down. Resident B was seated on the edge of the chair when CNA 3 went behind him, pulled him upward and back forcefully and said "g*dd**it (Resident B's name)" and aggressively said "you have got to sit still, you are too unsteady on your feet." CNA 4 went over to Resident B when she realized what had happened. CNA 3 went to the dining room and said "I hate this g*dd**n place." On 12/18/23 at 11:16 a.m., CNA 5 indicated on the night of the incident, she observed CNA 3 take Resident B to the bathroom. On the way back to the common area, CNA 3 appeared to be		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 proceeding on that basis. The Community 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. TAG 052 • Nurse completed head-to-toe skin assessments on all residents in memory care that were assigned to CNA in question, including Resident B, with no bruising or other signs of abuse found. Resident B was monitored for 72 hours for any psychosocial distress with none noted. Resident B's family and physician were notified. CNA in question is no longer employed by Community. • The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. • Abuse in-service	

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	aggressive with Resident B. CNA 3 was holding Resident B by the waist when he stumbled and CNA 3 said "come on (Resident B's name), I don't have all f**king night". Resident B fell into the chair and CNA 3 said "g*dd**it (Resident B's name)", then got behind the chair, pulled him up forcefully and yanked him towards the back of the chair. "It was abuse, you do not do anyone like that". CNA 4 had already headed over to Resident B to intervene. CNA 3 walked to the dining room and said "f**k this place." CNA 5 then went outside to report what had just happened to QMA 10. CNA 5 and QMA 10 came into the facility and met CNA 3 on their way in. CNA 3 looked and said "I did not do anything wrong, I quit and you do you." On 12/18/23 at 9:40 a.m., the Wellness Director provided a current copy of the document titled "Abuse Prevention Policy" dated 8/10/18. It included, but was not limited to, "Policy...It is the policy of the Facility to protect residents from abusive acts...Willful...A willful act is one the individual intended and one that the individual knew or should have known could cause physical harm, pain, or mental anguish...Physical Abuse...Includes, but is not limited to...controlling behavior...Verbal Abuse...Refers to the use of oral...language that willfully includes...derogatory terms to residents...or within their hearing distance, regardless of their age, ability to comprehend...." This Citation relates to Complaint IN00422665		completed with all staff on 11/26/23. Residents Rights in-service completed with all staff on 11/27/23. Abuse and Resident Rights in-services to be completed by Wellness Director or designee monthly for 3 months, then every other month for 3 months. • Weekly for two months the Wellness Director or designee will (i) conduct interviews with three care staff members (one from each shift) and two interview-able memory care residents and (ii) review shower logs for indications of physical abuse for six memory care residents. If any indications of abuse are found, said interviews and shower logs reviews will continue weekly for another two months and additional staff training will be conducted. Additionally, any occurrence will be reported and addressed per the Community's Abuse policy. If no indications of abuse are found during a two month period, the heightened monitoring will stop. • Systemic changes will be completed and in effect 1/14/24.	
R 0053 Bldg. 00	410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency (w) Residents have the right to be free from verbal abuse. Based on observation, interview and record	R 0053	This plan of correction is	01/02/2024

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	review, the facility failed to ensure staff to resident verbal abuse did not occur for 1 of 3 residents reviewed for abuse. (Resident B) Findings include: The clinical record for Resident B was reviewed on 12/18/23 at 10:18 a.m. The diagnoses included, but were not limited to, dementia, anxiety and sleep disorder. On 12/18/23 at 12:56 p.m., Resident B was observed lying in bed. A staff member was assisting the resident with a blanket and the resident showed not signs of any psychosocial distress. The incident report, dated 11/23/23 at 4:01 a.m., indicated CNA (Certified Nursing Assistant) 3 was observed by CNA 4 and CNA 5 to curse at Resident B from the bathroom to the common area. Once seated, CNA 3 pulled Resident B up in the chair. During an interview on 12/18/23 at 9:58 a.m., the Wellness Director indicated she received an early morning call on 11/23/23 from QMA (Qualified Medication Aide) 10 and reported CNA 3 walked off the job after she had screamed at Resident B. She went to the facility and assessed Resident B and all the residents on the Memory Care unit. During an interview on 12/18/23 at 10:34 a.m., CNA 4 indicated she and CNA 5 were seated in the dining room. Resident B often gets up to urinate and was unsteady on his feet. When CNA 3 forcefully pulled the resident back in his chair, the CNA said "g*dd**it (Resident B's name)" and aggressively said "you have got to sit still, you are too unsteady on your feet." CNA 4 went over		submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the 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 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 proceeding on that basis. The Community 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. TAG 053 • Nurse completed head-to-toe skin assessments on all residents in memory care that were assigned to CNA in question, including Resident B, with no bruising or other signs of abuse found. Resident B was monitored	

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	to Resident B when she realized what had happened. CNA 3 went to the dining room and said "I hate this g*dd**n place." During an interview on 12/18/23 at 11:16 a.m., CNA 5 indicated the night of the incident, she observed CNA 3 take Resident B to the bathroom. On the way back to the common area, CNA 3 appeared to be aggressive with Resident B. CNA 3 was holding Resident B by the waist when he stumbled and CNA 3 said "come on (Resident B's name), I don't have all f**king night". Resident B fell into the chair and CNA 3 said "g*dd**it (Resident B's name)", then got behind the chair, pulled him up forcefully and yanked him towards the back of the chair. "It was abuse, you do not do anyone like that". CNA 4 had already headed over to Resident B to intervene. CNA 3 walked to the dining room and said "f**k this place." CNA 5 then went outside to report what had just happened to QMA 10. CNA 5 and QMA 10 came into the facility and met CNA 3 on their way in. CNA 3 looked and said "I did not do anything wrong, I quit and you do you." On 12/18/23 at 9:40 a.m., the Wellness Director provided a current copy of the document titled "Abuse Prevention Policy" dated 8/10/18. It included, but was not limited to, "Policy...It is the policy of the Facility to protect residents from abusive acts...Willful...A willful act is one the individual intended and one that the individual knew or should have known could cause physical harm, pain, or mental anguish...Physical Abuse...Includes, but is not limited to...controlling behavior...Verbal Abuse...Refers to the use of oral...language that willfully includes...derogatory terms to residents...or within their hearing distance, regardless of their age, ability to comprehend...."		for 72 hours for any psychosocial distress with none noted. Resident's family and physician were notified. CNA in question is no longer employed by Community. • The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. • Abuse in-service completed with all staff on 11/26/23. Residents Rights in-service completed with all staff on 11/27/23. Abuse and Resident Rights in-services to be completed by Wellness Director or designee monthly for 3 months, then every other month for 3 months. • Weekly for two months the Wellness Director or designee will conduct interviews with three care staff members (one from each shift) and two interviewable memory care residents for indications of verbal abuse. If any indications of abuse are found, said interviews will continue weekly for another two months and additional staff training will be conducted. Additionally, any occurrence will be reported and addressed per the Community's Abuse policy. If no indications of abuse are found during a two-month period, the heightened monitoring will stop. • Systemic changes will be completed and in effect 1/14/24	

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