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	06/01/2023

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 IN00407967. Complaint IN00407967 - State deficiencies related to the allegations are cited at R0052 and R0214. Survey date: May 31 and June 1, 2023. Facility number: 010885 Residential Census: 96 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 6, 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 interview and record review, the facility failed to provide a safe environment and prevent an elopement resulting in the resident being found in a field outside the facility for 1 of 3 residents reviewed for neglect. (Resident B) Findings include: The record for Resident B was reviewed on 5/31/23 at 10:30 a.m. The diagnoses included, but were not limited to, anxiety and dementia with	R 0052	This Plan of Correction is submitted as required under State law. The submission of this Plan of Correction does not constitute an admission on the part of Riverbend Assisted Living as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. The submission of this Plan of Correction does not constitute an admission that the	06/22/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
William Jackson	Executive Director	07/05/2023

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.

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	06/01/2023

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
	behavioral disturbance. The Pre-Admission Evaluation, dated 4/25/23, indicated the resident did not have a history of elopement and had no behaviors of wandering. The physician's order, dated 5/2/23, indicated the resident received Xanax 0.25 mg (milligrams) two times daily as needed (PRN) for anxiety. The nurse's note, dated 5/2/23 at 1:16 p.m., indicated the resident was pacing the hallways and wanted to call her family. Staff called the resident's family and let the resident talk to them. She continued to appear anxious. Snacks and drinks were offered to the resident, and activities were provided but were not successful. PRN (as needed) anxiety medication (Xanax) was administered to the resident. The nurse's note, dated 5/3/23 at 1:58 a.m., indicated the resident was agitated that evening. She wanted to exit and get in her car to leave. She stated her family member needed to come and get her. She was redirected and calmed for 30 minutes and hung around the front door of the facility for an hour waiting on her family member to come and get her. Staff tried to redirect her but was unsuccessful. The resident was later sleeping in her room. The nurse's note, dated 5/4/23 at 4:43 p.m., indicated at 3:32 p.m. the CNA (Certified Nurse Aide) alerted the nurse and WD (Wellness Director) that the resident could not be located. Staff searched all interior rooms and around the perimeter of the building. At 3:36 p.m., the nurse and WD found the resident sitting in a field outside of the building. She had three small abrasions to the right side of her bottom lip and		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 judicial and/or administrative proceeding on that basis. The Community also 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. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;	

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	06/01/2023

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
	redness to the bottom of both feet. She denied pain and bruising or injuries. The resident did not appear to be in distress. Staff attempted to help the resident up off the ground and encouraged her to reenter the building. The resident stated " ... only God controls me ..." and would not stand up. The resident continued to talk about God and that staff could not control her. At 3:46 p.m., the WD spoke to the resident's family member, they indicated the resident had done this before in the past and typically had a UTI (urinary tract infection). Staff were able to get the resident up and back into the building. The resident was sent to the hospital for evaluation. The window stopper audit for the Memory Care unit, conducted on 5/5/23, indicated there were two resident rooms identified with windows that opened all the way, one that opened halfway, and another room that opened too far. The undated handwritten statement of CNA 4 indicated the resident was last seen on 5/4/23 in the dining area at 2:15 p.m. The undated handwritten statement of CNA 5 indicated the resident had last been seen on 5/4/23 around 2:15 to 2:20 p.m. She was feeding another resident her snack. The nurse's note, dated 5/4/23 at 5:05 p.m., indicated the resident's physician was notified of the transfer. The nurse's note, dated 5/4/23 at 11:18 p.m., indicated the resident was admitted to the hospital observation unit for severe dehydration. The lab work indicated the resident had increased troponin levels. An echocardiogram was scheduled and they would recheck the resident's		4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?; and 5. Date of systemic changes will be completed. **R052** 1. Resident B is residing in a safe environment to prevent elopements and is being monitored for wandering or exit-seeking behaviors. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. The measures that will be put into place and the systemic changes the Community will make to ensure that the deficient practice does not recur include safety audits daily for one month, and then once weekly by the Cottage Director or designee to ensure windows only open up to six inches. The maintenance department will audit windows twice weekly and calendar completion at the end of each round. In addition, on May 5,	

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	06/01/2023

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
	labs. The nurse's note, dated 5/5/23 at 2:46 p.m., indicated the resident returned from the hospital via her family's vehicle. The resident was started on fifteen-minute checks, thirty minute checks, and one hour checks for the next 72 hours. Her mood was calm. The nurse's note, dated 5/5/23 at 3:36 p.m., indicated the NP (Nurse Practitioner) was in to see the resident and gave no new orders for the resident to see psychiatric services if she had more anxiety or exit seeking. The nurse's note, dated 5/5/23 at 5:31 p.m., indicated the resident continued on every fifteen minute checks and staff were offering more fluids. She was still pacing around looking for her family. Staff redirected the resident to participate in activities. All staff were in-serviced by the WD, on 5/5/23, to always assist family members in and out of the building. No door codes were to be given to family members. If a family member utilized a code the WD was to be notified immediately. The incident form, dated 5/5/23, indicated the resident was a memory care resident. She had an abrasion to the bottom right side of her lip. It was unknown how she left the building. The alarms were functioning properly. The resident was not an elopement risk prior. The last elopement assessment was preadmission on 4/25/23, she did exhibit exit seeking and wandering behaviors. The resident was wearing a short sleeve shirt and pants, which were not sweatpants. The resident had not been identified as a concern for elopement. The temperature was 70 F. There was		2023, the Wellness Director in-serviced all staff on assisting family members in and out of the Community and not providing door codes to family members. Maintenance will change front door codes every 6 weeks and as needed. Furthermore, elopement drills will be monthly on each shift for three months, and quarterly thereafter. 4. The corrective action will be monitored by the Executive Director, Maintenance Director, or designee who will ensure that: (i) windows only open up to six inches, (ii) window audits are conducted twice weekly, (iii) family members are being assisted in and out of the Community and not provided door codes and (iv) elopement drills are conducted monthly on each shift. 5. Date of systemic change: June 22, 2023 **R214** 1. Resident D is no longer residing in the Community. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. The measures that will be	

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	06/01/2023

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
	no camera. The new intervention was to encourage the resident to participate in activities. The resident resided in the facility 5 days prior to the elopement. The resident's physician and family were notified. New interventions were to call the resident's family member if she was exit-seeking, encourage the family to decorate the room, monitor the resident's reaction to events and activities at the time of wandering behaviors. The rooms were audited with windows identified that opened too far. The service plan, last modified on 5/5/23, indicated the resident goal was to remain safe in the community. The interventions included, but were not limited to, encourage the resident to participate in activities, encourage the family to decorate the resident's room, staff were to frequently monitor the resident, staff were to monitor the resident's response to activities and events at time of wandering/exit seeking behaviors, and moved into a secured unit. During an observation and interview on 5/31/23 at 11:27 a.m., LPN (Licensed Practical Nurse) 3 walked around the back of the Memory Care unit building and pointed out where Resident B had been found. There was a hill leading down from the facility which led to an open field. In the far side of the field there was a storage shed. On the other side of the shed was a street where vehicles were observed to be passing frequently. LPN 3 indicated it was still a mystery how the resident got down to the field, but she had found the resident down near the shed in the field. The resident's shoes had been found closer to the facility, near a fence to the left of the building by a pond. She had not noticed any exit seeking behavior prior to the incident, and she had been in a group activity. She was not aware of the		put into place and the systemic changes the Community will make to ensure that the deficient practice does not recur include the Wellness Director or Designee will in-service all care staff on: (i) reporting all falls to the Wellness Director and/or Qualified Medication Aide and logging the fall in the communication log, and (ii) the Fall Management Handbook including post-fall assessments and interventions. 4. The corrective action will be monitored by the Wellness Director or designee who will audit the communication log for falls to ensure all appropriate post-fall assessments and interventions have been implemented. This audit will occur daily for 4 weeks, then twice a week for 4 weeks, then weekly for 8 weeks followed by monthly for 8 weeks. 5. Date of systemic change: June 22, 2023	

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	06/01/2023

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
	resident having any exit seeking behaviors prior, but she had gone to the front door and asked to go outside. During an interview on 5/31/23 at 11:38 a.m., the WD indicated they could not ascertain how the resident got out of the facility. They did check windows immediately after they found her, and assured she was safe. They did find windows that were not secured. They found 3 windows that did not have the stoppers on them and there was one window towards the back of the building that was opened. It was facing the field where she was found. She did feel it was more likely she got out via the window. There were 3 CNA's in the activity area and a nurse in the nurse's station. It was a bedroom window of another resident, who liked to leave her door unlocked. There was no blood on the window. The window did not have a stopper. From her understanding they were supposed to have stoppers on the windows. They were only supposed to open a certain amount and the stopper was a backup. The maintenance director was to audit every so often, but after this happened they were auditing weekly. Prior she was not sure how often they were auditing. She believed monthly. She did not know how or when the stoppers became not present in the windows. During an interview on 5/31/23 at 12:00 p.m., the Maintenance Director indicated he was responsible for auditing the windows on the unit. He was aware of the incident where the resident got out of the building. Normally they checked those windows once a week. They did a walk through usually on Wednesdays, but sometimes more often. He was doing that prior to her getting out of the facility. The reason why they checked the windows was because sometimes family members would open the window and would take			

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	06/01/2023

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
	the screws out. They would do this to be able to open the window higher if they wanted more air into the building. Since then, that had added more security to the windows in the form of longer screws which would take someone like himself with a drill to remove. Prior to adding longer screws it would have just taken a screwdriver to remove the stoppers. He did not think any of the residents could do it, but a family member could have. He audited the windows on the Wednesday before she got out, but they were not recording the audits prior. They did not have any audit logs for his checks prior to the resident getting out of the facility. It was Tuesday or Wednesday before the resident got out and he looked at the windows. He did not locate any that needed to be fixed on that date. He believed the window they found open was in a room with two residents. A family member could have adjusted it to where the window was up higher. During an interview on 6/1/23 at 9:20 a.m., the ED (Executive Director) indicated the windows were supposed to be checked daily prior to the elopement by the Memory Care director. During an interview on 6/1/23 at 9:42 a.m., the Memory Care Director indicated she had conducted safety checks since she had been there which was over two years. When she first started she was told every day she was to go in the rooms and check for safety hazards, including looking at the windows and egresses. There were plastic strips in the windows with screws in them. She went room to room and checked every window. She would lift them to make sure they were not loose, and she let maintenance know or fixed it herself if she had a tool handy. Since the elopement, she checked them in the morning and the afternoon. Prior to the elopement she was			

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	06/01/2023

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
	going in every room every day and checking the windows. She was documenting it. She was looking to see if the stoppers were in place. She did not know about 3 to 4 windows that were not working properly. She had checked every window the day before. She would say that when a family moved in recently she had to tell them not to take the screws out of the window. They unscrewed the windows with a drill. She told them it was a safety issue and they put it back. During an interview on 6/1/23 at 11:13 a.m., the WD indicated her elopement assessment was a very small part of her pre-assessment. During the assessment the resident's family indicated she had no history of elopement or wandering behavior. The family did not tell her the resident tried to get out of the house or anything. They called the family when she was exit-seeking. They tried to keep her in the common areas in the line of sight. She was uncertain if they initiated more frequent checks at the time. At 11:31 a.m., the WD indicated staff did every two hour monitoring of the residents. They did not increase the monitoring when the resident was initially exit-seeking. They were trying to implement the other interventions, such as calling the family, giving the medication, and things like that. She had been anxious since she moved in. She was aware of the resident displaying exit seeking behaviors on 5/2/23. That was when she became increasingly anxious. When they became aware, they implemented calling the family and doing a facility activity. They increased the frequency of her monitoring when she returned from the hospital from her elopement. Her monitoring was now every 2 hours. They did not have any behaviors documented on the resident's behavior log on 5/2/23 or 5/3/23, however they were documented in the nurses notes.			

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	06/01/2023

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
	The facility's Dementia Unit Program Checklist was provided on 6/1/23 at 11:50 a.m. by the ED. The checklist included but was not limited to, " ... Safety is a top priority. Communities will ensure ... Door entry codes are controlled ... Window stops are checked daily ..." The most current, but undated, Elopement Policy, provided on 5/31/23 at 11:00 a.m., included, but was not limited to, " ... If the Resident continues to Exhibit Elopement Tendencies, suggest that the Resident undergo a Doctor's Examination to Determine if ... Medication is required ... A medication change is necessary ... or Some other type of medical/behavioral intervention might help improve the resident's condition ... During this investigatory period ... alert all employee partners ... of the need to monitor the resident on a regular basis ... Make sure windows can only be opened six to eight inches ..." This State deficiency relates to Complaints IN00407967.			
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to ensure adequate assessment of a resident who experienced a fall for 1 of 3 residents reviewed for resident evaluation. (Resident D)	R 0214	This Plan of Correction is submitted as required under State law. The submission of this Plan of Correction does not constitute an admission on the part of	06/22/2023

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	06/01/2023

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
	Findings Include: The record for Resident D was reviewed on 5/31/23 at 11:40 a.m. The diagnoses included, but were not limited to, acute kidney failure, atrial fibrillation, anemia, cerebral infarction, and vitamin deficiency. The handwritten statement of CNA (Certified Nurse Aide) 6, dated 4/15/23, indicated the CNA helped the resident from the floor on her back to her bed on 4/14/23. She did not report it to the QMA (Qualified Medication Aide) on shift. The record lacked documentation of any notification to the nurse of a fall, or any assessment of the resident after a fall incident on 4/14/23. The nurse's note, dated 4/16/23 at 5:02 p.m., indicated the resident's family member said the resident was complaining about back pain earlier. Tylenol was administered. The resident's family member was concerned about her hip because she had surgery a year ago and requested an x-ray. The NP (Nurse Practitioner) was notified and gave new orders to obtain an x-ray of the right and left hip. The x-ray report, dated 4/16/23, indicated the resident had no radiographic evidence of fracture or dislocation to the right hip. The nurse's note, dated 4/18/23 at 12:49 p.m., indicated the resident complained of low back pain. Tylenol was given with effective results. The resident was up for meals and utilizing her wheelchair. The nurse's note, dated 4/21/23 at 3:14 p.m.,		Riverbend Assisted Living as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. The submission of this Plan of Correction 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 judicial and/or administrative proceeding on that basis. The Community also 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. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;	

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	06/01/2023

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
	indicated the NP was in to see the resident for complaints of pain in her lower back. An x-ray was ordered for the lower back. The x-ray report, dated 4/21/23, indicated there were no acute changes to the thoracic spine. The lumbosacral spine 2 view results indicated normal lordosis of lumbar spine with no subluxation, visualized vertebral bodies were intact, no compression deformities, mild osteopenia, and mild osteoarthritis. The nurse's note, dated 4/22/23 at 10:27 a.m., indicated the results showed no fracture and arthritic changes. The NP was notified of the results and gave an order to refer the resident to a specialist. The family member indicated the resident used to get spinal injections but did not know who the doctor was. The facility requested the family to find out and let them know so they could make the appointment. The nurse's note, dated 4/22/23 at 10:05 p.m., indicated the resident was stating her family member was lying in the corner and people were walking around outside her window. The resident's representative and physician were notified. The nurse's note, dated 4/23/23 at 12:03 p.m., indicated the resident was unable to sit up on the side of the bed and was complaining of pain. The resident was unable to transfer from sit to stand but was able to stand up at the side of the bed. The family was present and requested she go to the hospital. The nurse's note, dated 4/23/23 at 4:51 p.m., indicated the resident was admitted to the hospital for sepsis, pneumonia, and a closed fracture of the		3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?; and 5. Date of systemic changes will be completed. **R052** 1. Resident B is residing in a safe environment to prevent elopements and is being monitored for wandering or exit-seeking behaviors. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. The measures that will be put into place and the systemic changes the Community will make to ensure that the deficient practice does not recur include safety audits daily for one month, and then once weekly by the Cottage Director or designee to	

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	06/01/2023

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
	L1 vertebrae. The late entry note, dated 4/17/23 and documented on 4/23/23 at 7:34 p.m., indicated on 4/17/23 the resident's family member had contacted the WD (Wellness Director) and indicated the resident had told the family member she had fallen but was not sure when. The WD asked multiple staff members if they had witnessed a fall. A CNA reported the resident fell 4/14/23 at 5:00 a.m., and she assisted her up but failed to report the fall to the nurse or QMA. The CNA stated during rounds she went into the resident's room and observed her on the floor in the bathroom and helped her up. The hospital report, dated 4/26/23, indicated the resident admitted to the hospital on 4/23/23 and was treated with sludge in gallbladder, pneumonia of right lung, closed compression fracture of body of L1 vertebrae, acute midline low back pain, and sepsis. The resident had a L1 fracture and suspected pneumonia. A brace and antibiotics and therapy were ordered. Therapy services recommended the resident go to a rehabilitation facility. Her pain was controlled, and she felt much better. Cultures were negative. Her acute kidney injury resolved with fluids. No further inpatient workup was required, and she was stable to discharge to the rehabilitation center. During an interview on 5/31/23 at 11:49 a.m., the WD indicated the resident had a fall on 4/14/23. They had completed x-rays and they were clear, however the hospitals x-rays showed a fracture. During an interview on 6/1/23 at 12:16 p.m., the WD indicated if a resident was found on the floor staff were to tell the QMA or nurse, and the nurse would assess the resident. Residents were to be		ensure windows only open up to six inches. The maintenance department will audit windows twice weekly and calendar completion at the end of each round. In addition, on May 5, 2023, the Wellness Director in-serviced all staff on assisting family members in and out of the Community and not providing door codes to family members. Maintenance will change front door codes every 6 weeks and as needed. Furthermore, elopement drills will be monthly on each shift for three months, and quarterly thereafter. 4. The corrective action will be monitored by the Executive Director, Maintenance Director, or designee who will ensure that: (i) windows only open up to six inches, (ii) window audits are conducted twice weekly, (iii) family members are being assisted in and out of the Community and not provided door codes and (iv) elopement drills are conducted monthly on each shift. 5. Date of systemic change: June 22, 2023 **R214** 1. Resident D is no longer residing in the Community. 2. The Community reviewed	

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	06/01/2023

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
	assessed after every fall. The Fall Management Handbook, dated 7/1/16, provided on 5/31/23 at 11:00 a.m., included, but was not limited to, " ... Post-fall Interventions ... Take vital signs ... Inspect for any injuries, bruises, swelling, or lacerations ... Evaluate for Pain ... Evaluate for changes in level of consciousness ... Notify Wellness Direector or Executive Director if a licensed nurse is not in the building ... Notify the attending physician and implement physician's orders ... In accordance with the facility policy, notify the Resident Care Coordinator/Wellness Nurse/Executive Director ... Monitor the resident and place the resident on Alert Charting ... for 72 hours following a fall ... Document results of the assessment and condition of the resident, physician's orders, care rendered, and notification to the physician, family/representative, and emergency transport used..." This State deficiency relates to Complaints IN00407967.		each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. The measures that will be put into place and the systemic changes the Community will make to ensure that the deficient practice does not recur include the Wellness Director or Designee will in-service all care staff on: (i) reporting all falls to the Wellness Director and/or Qualified Medication Aide and logging the fall in the communication log, and (ii) the Fall Management Handbook including post-fall assessments and interventions. 4. The corrective action will be monitored by the Wellness Director or designee who will audit the communication log for falls to ensure all appropriate post-fall assessments and interventions have been implemented. This audit will occur daily for 4 weeks, then twice a week for 4 weeks, then weekly for 8 weeks followed by monthly for 8 weeks. 5. Date of systemic change: June 22, 2023	