STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND	2715 CHARLESTOWN PIKE, JEFFERSONVILLE, , 47130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intakes 471479 and Intake 471611. Intake 471479 - State deficiency related to the allegation is cited at R0273. Intake 471611 - State deficiency related to the allegation is cited at R0052. Survey date: September 24, 2026 Facility number: 010885 Residential Census: 75 These State Residential Findings are cited in accordance with 410 IAC (Indiana Administrative Code) 16.2-5. Quality review completed on October 6, 2026.	R 0000	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 Senior 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.	
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (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 resident to resident abuse did not occur resulting in resident-to-resident physical and mental inappropriate abusive interactions for 5 of 6 residents reviewed for abuse. (Residents C, B, J, K, and L) Findings include: The record for Resident C was reviewed on 9/24/26 at 9:40	R 0052	R0000 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 Senior 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	10/18/2026

	a.m. The resident's diagnoses included, but was not limited to, acute psychotic disturbance, dementia (decline in mental ability severe enough to interfere with daily life), vascular dementia with behavioral disturbances (reduced blood flow to the brain causing damaged tissue causing changes in mood and conduct). The physician's order, dated 5/2/26, indicated staff were to administer Resident C's donepezil (used to treat confusion and memory loss) at night at 8:00 p.m. The physician's order, dated 5/2/26, indicated staff were to administer Resident C's memantine (used to treat moderate to severe symptoms of Alzheimer's a brain disorder that slowly destroys memory and thinking skills) twice daily at 8:00 a.m. and 8:00 p.m. The nurse's note, dated 6/26/26 at 10:30 p.m., a Certified Nurse Aide (CNA) indicated that Resident J was in Resident C's bed with him. The residents were redirected without occurrence. The residents were placed on 15-minute checks. Resident J's and Resident C's psychosocial wellbeing was monitored. The nurse's note, dated 6/28/26 at 11:23 a.m., indicated that		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. The clinical team assessed Residents B, C, J, K, and L for physical injury, psychosocial distress, and any need for additional interventions. Assessments, notifications, and follow-up will be completed and documented as indicated. The community is working on a 30-day discharge notice for Resident C. 1. All resident charts will be reviewed to determine the potential that they may be affected. The Executive Director and clinical team will review resident behaviors, incident reports, and service plans to identify additional residents who may be at risk for inappropriate interactions or abuse. Identified concerns will be addressed through	

	Resident C was joking around with another male resident with a butterknife and indicated, "I'm going to pop your belly!" Education was provided to not point butterknives at other resident's, even if it was a joke. The unidentified male resident and Resident C resided on the dementia unit. The nurse's note, dated 7/6/26 at 11:07 a.m., indicated that Resident C was observed telling Resident B something and then stuck out his tongue at her. Education was provided to Resident C that it was inappropriate sexual behavior and to please refrain from antagonizing female residents. Resident C laughed and indicated, " I was just joking." Resident B was removed from the common area and distracted into cleaning her room. Resident C then went to his room after Resident B was no longer near him. The service plan, dated 7/13/26, indicated Resident C's care team would monitor for changes in the resident's condition and conduct a reappraisal as appropriate. On 6/26/26, the resident would be monitored for psychosocial distress for 72 hours; he had behavior checks in place every 15 minutes for 24 hours, every 30 minutes for 24 hours, and every 1 hour for 24		individualized interventions and updated service plans as indicated. 1. All staff will be re-educated on residents' rights, abuse prevention, recognition and reporting of resident-to-resident abuse, and immediate protective actions. The clinical team will review and update interventions for residents with identified behavioral risks, including supervision requirements, room placement, environmental modifications, and redirection strategies. Staff will promptly report incidents and changes in behavior. The clinical team will collaborate with treating providers as indicated and reassess interventions when behaviors recur or existing measures are ineffective. 1. The Executive Director or designee will review behavioral incidents and allegations of abuse daily for 30 days, weekly for the following 60 days, and monthly for three additional months. Audits will include incident	

	hours. On 7/3/26, the resident was monitored for psychosocial distress every 72 hours. The behavior checks were to be in place every 15 minutes for 24 hours, every 30 minutes for 24 hours, and every 1 hour for 24 hours. The care plan, dated 7/13/26, indicated Resident C's special needs were for staff to provide support with special care needs. The staff were to provide safety checks every two hours. The service plan, dated 7/13/26, indicated Resident C needed frequent help due to disorientation, memory loss, and difficulty completing tasks. The interventions included but were not limited to; the Care Team were to support the resident with orientation, redirection and wayfinding. The nurse's note, dated 7/28/26 at 4:05 p.m., indicated the Psychiatric Nurse Practitioner (NP) saw Resident C for increased sexual behaviors. New orders were received to discontinue escitalopram (used to treat major depressive disorder and generalized anxiety) and start 10 mg of citalopram (used to treat depressive disorders) daily and 100 mg of medroxyprogesterone (used to manage severe behavioral or		follow-up, service plan accuracy, and implementation of required interventions.	

	hormone-sensitive conditions) daily. The nurse's note, dated 8/1/26 at 7:07 a.m., indicated a CNA observed Resident C grab Resident L on her bottom and the CNA walked the resident to his room. Fifteen-minute sexual behavior checks were initiated for Resident C per facility protocol. The nurse's note, dated 8/4/26 at 2:33 p.m., indicated the Psychiatric Nurse Practitioner was in the facility with new orders for Resident C. The resident was to discontinue the Medroxyprogesterone and to start Estradiol (used for hormone therapy), transdermal, every Wednesday. The nurse's note, dated 8/6/26 at 10:10 a.m., indicated Resident C's Estradiol patch was started and applied to the right upper arm without adverse effects. No complaints were voiced. The nurse's note, dated 8/12/26 at 9:11 a.m., indicated Resident C's family called the facility to let them know she received a letter from his insurance company indicating the Estradiol was not covered and a small supply had been sent. The nurse's note, dated 8/12/26 at 5:28 p.m., indicated that			

	Resident C attempted to touch a female resident's chest (Resident K). Resident C was immediately directed to his room and educated not to touch any other residents. Resident K and Resident C resided on the dementia unit. The nurse's note, dated 8/13/26 at 3:58 a.m., indicated that Resident C was placed on 15-minute sexual behavior checks, with the resident in his room. No further behaviors were observed. The nurse's note, dated 8/18/26 at 11:19 a.m., indicated the Psychiatric Nurse Practitioner (NP) had new orders for Resident C. The staff were to discontinue the resident's Citalopram, 10 mg and were to start Citalopram, 20 mg daily for depression. The nurse's note, dated 8/21/26 at 7:01 a.m., indicated Resident C was in his room, getting out of bed when staff opened the door and found Resident B standing at the door putting on her panties. Resident C denied anything happening. A call was placed to the psychiatric NP to notify of the occurrence. The NP recommended sending Resident C to a behavioral hospital. A call was placed to the resident's family member to notify of the occurrence, a referral was sent			

	for the resident to be sent to a behavioral hospital, and the resident would be moving rooms to another hall. The State Reportable report, dated 8/21/26, indicated, Resident B was in Resident C's room with her pants off. Resident C was laying in his bed. Both residents were placed on behavior checks every 15-minutes for 24 hours and every 1 hour for 24 hours. Resident C was referred to a behavioral hospital. The nurse's note, dated 8/21/26 at 11:39 a.m., indicated Resident B's family member and Psychiatric NP were called to notify them of the occurrence with Resident C. Resident B was placed on behavior checks. The nurse's note, dated 8/21/26 at 11:43 a.m., indicated the Resident C would remain on behavior checks until he was transported to the behavioral hospital. The nurse's note, dated 9/1/26 at 7:52 a.m., indicated Resident C returned to the facility. A new order was received for Resident C to receive 250 mg of Depakote (used to treat bipolar disorders) twice daily. The record for Resident J was reviewed on 9/24/26 at 9:42 a.m. The resident's diagnoses			

	included, but was not limited to, acute psychotic disturbance, dementia. The resident's service plan was for two-hour staff safety checks. The record for Resident B was reviewed on 9/24/26 at 9:44 a.m. The resident's diagnosis included, but was not limited to, dementia. The resident's service plan was for two-hour staff safety checks. The record for Resident L was reviewed on 9/24/26 at 9:46 a.m. The resident's diagnosis included, but was not limited to, dementia. The resident's service plan was for two-hour staff safety checks. The record for Resident K was reviewed on 9/24/26 at 9:48 a.m. The resident's diagnosis included, but was not limited to, dementia. The resident's service plan was for two-hour staff safety checks. During an observation in the Cottage, on 9/24/26 at 11:35 a.m., Resident C was sitting at a two-person table with a male resident. When he finished his meal, he talked with the other male resident. He was then brought into the common area and sat in a chair next to a female resident in the common area. During an interview, on 9/24/26			

	at 11:37 a.m., Certified Nurse Aide (CNA) 5 indicated Resident C had no recent behaviors. He was friendly at times to other residents. He was flirtatious with female residents. The interventions used for Resident B were to separate him from females, conduct hourly checks, and to not let him sit next to female residents. When there was an incident, the resident listened and cooperated with staff. He would either be in his room or bedroom, or staff took him outside to sit on the porch. During an interview, on 9/24/26 at 11:50 a.m., Licensed Practical Nurse (LPN) 3 indicated Resident C's behaviors started on day one, when the resident had been admitted from a behavioral hospital. The resident was sexually inappropriate and was sexually insulting. He tried to enter female resident's rooms. The resident was all right for a few days after returning from the behavioral hospital but would return to being inappropriate after that. Resident C's room was next to Resident B's room. Resident C was supposed to be moved to another room, but that never happened. Resident C could be redirected, then a half hour later he was back to being inappropriate. He had ladies in his bed at least two or three times. He would always sit by a			

	female resident. He had grabbed Resident L's bottom and grabbed Resident K's chest. Resident B was now more sexual since the incident with Resident C. Resident J was found in bed with Resident C. She was now discharged from the facility. During an interview, on 9/24/26 at 12:20 p.m., the Executive Director (ED) indicated she felt that Resident C was appropriate for the Cottage. The ED had worked with the Nurse Practitioner on how to handle Resident C's behaviors. The interventions were occasionally preventing the resident from his behaviors. The resident had been back from the behavioral hospital only a couple of weeks and nothing else had occurred. They wanted to ensure residents were safe. The ED indicated she had worked with clinical on his behaviors. The possibility of the resident being relocated to another facility had been discussed, but she felt he was appropriate for the facility. The interventions tried for Resident C were for checks, and medication changes, along with the behavioral hospital. If needed, they would have to discuss moving him to a male hall in the facility. Then if those didn't work, they would look for another placement. The resident stayed mostly in the dining room			

	or common areas. The Abuse Prevention Policy, dated 8/10/18, included, but was not limited to, "... Policy: It is the policy of the Facility to protect residents from abusive acts and to adequately train Facility personnel in methods of detection and prevention of abuse... 7. Staff will be trained annually to identify behaviors which could potentially lead to abuse. Behaviors which will not be tolerated by the Facility include a. Being disrespectful. b. Use of vulgar language or derogatory terms. c. Inappropriate gestures..." This citation relates to Intake 471611.			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. During an interview with Resident F, on 9/24/26 at 7:35 a.m., she indicated the food was usually burnt. It did not matter what the food was, it was burnt. The sloppy joes surved last night were very liqified and	R 0273	1. Identified kitchen sanitation concerns were corrected, and food products that were expired, deteriorated, or otherwise unsuitable for consumption were discarded. Kitchen equipment and food preparation areas were cleaned. Food preparation and service practices will be reviewed to ensure meals are properly cooked and served at appropriate temperatures.	10/18/2026

	watered down and not edible. This had been occurring over the last several weeks. During an interview with Resident G, on 9/24/26 at 7:37 a.m., she proceeded to show the pictures of the food being served on her phone. Among the pictures were burnt dinner rolls, hard toast, burnt waffles, burnt cookies, and burnt grilled cheese. The resident indicated almost every meal some foods are burnt. During a kitchen observation and interview, on 9/24/26 at 7:45 a.m., the following was observed: - The microwave had a piece of dried egg on the glass spin table inside. The four corners inside the microwave had a moderate build up of brown/black dried material. During an interview with Cook 6 at this time, he indicated he never used the microwave and did not know who was the last person to use it. The review of the Cooks' cleaning log for 9/20/26 to 9/23/26, the microwave was checked off as having been cleaned. - The hand washing sink by the dry storage room, had a brown coffee-like stain in the bottom half of the sink. The Daily Cleaning/Sanitation		1. All residents have the potential to be affected by improper food handling and sanitation practices. The Dietary Manager or designee will inspect all kitchen areas, including the Cottage kitchen, refrigerators, ovens, microwaves, ranges, and food storage areas, and correct any identified concerns. 1. All dietary staff will receive in-service education on proper food handling, storage, date labeling, discard dates, cooking temperatures, meal quality, and kitchen sanitation. A written cleaning schedule will identify required tasks and their frequency. Staff will be educated that cleaning checklists must be initialed only after tasks have been completed and verified, not simply to complete the documentation. The Dietary Manager or designee will verify cleaning completion and conduct daily inspections. Food storage areas will be checked daily for expired, deteriorated, or improperly	

	Log, revised 7/1/22, indicated for the week of 9/21/26, the following Kitchen Cleaning Items were initialed as completed by staff for 9/24/26: -Microwave (Clean inside and out; remove food splatters and crumbs) -Range (Clean shelves above stove; range grates, all surfaces) -Oven (Check to remove crumbs, spills) Food Safety/Sanitation Checks: -Discard wilted/moldy produce This State Residential tag is related to Intake 471479 Based on observation, record review and interview, the facility failed to ensure food was served properly cooked and the kitchen was maintained in a safe and sanitary manner. This deficient practice had the potential to affect 75 of 75 residents currently residing at the facility. Findings include: During an observation and interview, on 9/24/26 at 7:40 a.m., Cook 6 was wiping down the stove top. He had completed cooking for breakfast.		labeled products. Food temperatures will be checked and documented as required by applicable regulations and facility policy. Meals will be inspected before service, and undercooked, burned, or otherwise unacceptable food will be corrected or replaced. Appropriate alternative meal options will be available to residents who decline the scheduled meal. 1. The Dietary Manager or designee will conduct and document daily kitchen sanitation, food storage, and food safety audits for 30 days, weekly for 60 days, and monthly for three additional months. Any identified concerns will be corrected immediately, with additional education or monitoring provided as needed. Results will be reviewed by the Executive Director and Dietary Manager, with ongoing compliance monitored through the facility's quality assurance process.	

The following concerns with kitchen equipment were observed:

-The stove had black charcoal around the grates.

-The large drip pan under the burners had foil, which was covered in a thick, dried on, yellow substance across 100% of the area.

-The small drip pan in the center of the stove had foil that was covered with macaroni, food particles, and grease.

-The small drip pan on the right side of the stove, under the flat top had thick brown grease. When the pan was pulled out, grease streaks started to run down the front of the oven door onto the floor.

-Both of the ovens had black charcoal build-up on the bottom inside of the oven.

-In one of three refrigerators, a bag of slaw or chopped lettuce was dated 9/22/26 and had brown edges. There was a bag of shredded iceberg lettuce, with a use by date of 8/31/26. There was a light brown liquid in the bottom of the bag. There was a tub of banana pudding in the refrigerator, with an open date of 9/17/26.

At this time Cook 7 indicated the

	Executive Director (ED) had been in charge of the kitchen since the Dietary Manager had her surgery a month ago. During an interview, on 9/24/26 at 11:27 a.m., Cook 6 indicated soups and pudding could be kept for 7 days; the lettuce and fruit could be kept for 3 days. During a follow up observation in the kitchen, on 9/24/26 at 11:15 a.m., the following was observed: the drip pans had been cleaned and the foil replaced. The slaw or lettuce mix had been removed from the refrigerator, but the shredded iceberg lettuce was still in the refrigerator. The black charcoal was still in the bottom of the oven and the scoop had been removed from the sugar tub.			

	During an interview, on 9/24/26 at 11:27 a.m., the Executive Director (ED) indicated the dates on the puddings and soups were the open dates, not the use by dates. Cook 9 was in charge in the Cottage kitchen. She felt that the cleaning could always be better. Residents asked for a lot of different food preferences, so some of the cleaning was not taken care of. She had heard of complaints about the food alternatives, but not the food in general. She had not heard of food being overcooked, undercooked or burned from residents. During an interview and observation, on 9/24/26 at 11:48 a.m., Cook 7 indicated the cooks cleaned as they went along. There was no schedule for cleaning. All cooks checked the refrigerator to make sure food had not expired. At this time, the stove was observed and the drip pan had thick yellow build-up with food particles on the foil liner. The stove top had black charcoal around the burners. The oven was filled with a large sheet cake baking, but there was a light coating of charcoal built-up on the inside of the oven floor. Cook 7 indicated the oen was probably unclean. During an interview with Licensed Practical Nurse (LPN)			

	3 and Certified Nurse Aide (CNA) 4, on 9/24/26 at 11:50 a.m., they indicated the food was often undercooked, especially the meat and vegetables like broccoli and green beans; and sometimes the other foods were burnt. LPN 3 indicated that the residents in the Cottage might be confused, but knew enough to complain if they did not like the main meal and would ask for an alternative. The only alternative food they were able to offer the residents was a peanut butter and jelly sandwich. There was no other food items available for staff to offer the residents. During an interview, on 9/24/26 at 11:55 a.m., Licensed Practical Nurse (LPN) 3 indicated the food was not good at times at the facility. The facility didn't hire trained cooks, just high school graduates. The food was undercooked or over cooked and burnt. This occurred more during the lunch and supper meals. The residents in the Cottage commented on the issues with the food preparation.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURETori Harper	TITLEExecutive Director	(X6) DATE10/19/2026