

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155621	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/10/2024
NAME OF PROVIDER OR SUPPLIER  River Bend Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  3400 Stocker Dr Evansville, IN 47720	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35733</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure adequate safety measures were in place for safe transport for 1 of 3 residents reviewed for accidents. This deficient practice resulted in Resident B obtaining injuries that resulted in medical intervention and fractures. (Resident B)</p> <p>Finding includes:</p> <p>On 9/9/24 at 10:30 a.m., two state reportable's for Resident B were reviewed and included, but were not limited to:</p> <p>State Reportable 1</p> <p>Incident date: 8/28/24</p> <p>Incident time: 2:01 p.m.</p> <p>Description added: 8/29/2024 Resident was out to an appointment. As the driver was taking her into the appointment the resident's foot caught beneath the wheelchair and twisted.</p> <p>Type of injury added: 8/29/2024 Fracture to her left ankle</p> <p>Immediate action added: 8/29/2024 Resident will have foot rests on her wheelchair when out for appointments. Driver was educated on safety. Resident was seen by ortho and sent to be fitted with a splint on 8/29/24. Therapy applied brace until resident was fitted for splint.</p> <p>Type of preventative measures taken: 8/29/2024 Therapy to evaluate for proper foot rests.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155621	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/10/2024
NAME OF PROVIDER OR SUPPLIER  River Bend Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  3400 Stocker Dr Evansville, IN 47720	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>Follow up added: 9/5/2024 Driver was interviewed and stated that resident's leg rests were not on her wheelchair because she self-propels when he took her for her appointment. The leg rests were available in the van. When he was pushing the resident into the appointment, the residents foot was caught under the wheelchair. Resident confirmed that foot was injured during transport. Driver was re-educated on safe transport on 8/29/24. His employment was terminated on 8/30/24. An audit was completed by 8/30/24 on all residents who use a w/c and foot pedals will were placed in a bag on the back of their w/c. All staff were re-educated on the facility's w/c policy by 8/31/24 or before working any shift. All new hires will be inserviced as well before providing any care to a resident.</p> <p>State Reportable 2</p> <p>Incident date: 8/29/24</p> <p>Incident time: 4:01 p.m.</p> <p>Description added: 8/30/2024 Resident was being transported to an appointment when she started sliding out of her chair. The driver stated that she had slid all the way out of her chair before he could pull over safely. Nursing staff met the driver and resident at their location asap [as soon as possible]. They evaluated the situation and called EMS [Emergency Medical Services]. Resident was taken to the hospital for evaluation and it was discovered that she had a fractured right ankle. Driver was suspended from driving pending investigation. The physician, responsible party, ED [Executive Director] and DON [Director of Nursing] were notified. Resident is being assessed for pain and discomfort and will appropriately address as indicated. SS [Social Services] to provide psychosocial support as indicated.</p> <p>Type of injury added: 8/30/2024 Fracture to right ankle</p> <p>Immediate action taken: 8/30/2024 Driver was suspended pending investigation.</p> <p>Type of preventative measures added: 8/30/2024 All staff will be educated on wheelchair safety before working their next shift. All Drivers [sic] will be educated on safety protocols while transporting residents before driving any residents.</p> <p>Follow up added: 9/5/2024 Driver reported that he thought he had put the seatbelt on properly. While interviewing the driver it was discovered that he hadn't put the seatbelt on properly. Driver had been educated on safe transport of wheelchair seated passengers on 7/26/24. Driver was terminated on 8/30/24. Resident reports that she continues to feel safe in the facility. All staff were re-educated on the facility's abuse/neglect by 8/31/24 or before working any shift. All new hires will be inserviced as well before providing care to any resident. All drivers re-educated and will successfully pass a return demonstration to ensure they are competent on safe transfers before they transport any resident in the facility van.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155621	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/10/2024
NAME OF PROVIDER OR SUPPLIER  River Bend Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  3400 Stocker Dr Evansville, IN 47720	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/9/24 at 10:50 a.m., the Administrator indicated incident one happened on 8/28/24, it was reported to him the next day, he reported it as a state reportable when he found out Resident B had sustained a fracture to her left ankle. The driver reported he had been pushing the wheelchair when the residents foot got caught under the wheelchair, footrests were not on, but were in the van, the driver knew they were supposed to be on the wheelchair. The Administrator indicated the driver had been educated on safe transport after the incident. The Administrator indicated incident two happened on 8/29/24 while Resident B was being transported in the facility van to an appointment, Resident B sustained a fracture to her right ankle. Resident B slid out of her wheelchair, the driver reported he thought he had properly secured the seatbelt, but had not, the driver had been educated on seatbelt use on 7/26/24 when it was added to the van.</p> <p>On 9/9/24 at 11:03 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, other fracture of right lower leg, other fracture of left lower leg, unilateral primary osteoarthritis, diabetes mellitus, and pain.</p> <p>A quarterly MDS (Minimum Data Set) assessment, dated 7/1/24, indicated Resident B's cognition was intact, wheelchair for mobility, bed mobility extensive two assist, transfer total dependence two assist, self care-toileting dependent, shower/bath substantial/maximal assist, lower body dressing dependent, substantial/maximal assist, wheel chair 150 feet, once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space dependent.</p> <p>Care plans included, but were not limited to:</p> <p>Alteration in musculoskeletal status related fracture to left ankle, fracture to right ankle, date revised on 8/30/24. Interventions included, but were not limited to: Foot pedals to be on wheelchair at all times when out of facility, initiated, 8/30/24. Wear splint to left foot/ankle and Ace wrap to right foot/ankle at all times until further orders, initiated 8/30/24.</p> <p>The resident is at risk for falls, gait/balance problems related to morbid obesity, impaired mobility, sit to stand lift, pain, poor eye sight, psychotropic use, revised on 7/26/24. Interventions included, but were not limited to, anticipate resident needs, educate the resident/family/caregivers about safety reminders and what to do if a fall occurs, ensure resident is wearing proper footwear such as non-skid socks when ambulating or in wheelchair, initiated 2/9/23.</p> <p>The resident has an ADL (Activities of Daily Living) self-care performance deficit related to OA (osteoarthritis), bladder incontinence, decreased mobility, revised on 7/26/24. Interventions included, but were not limited to, transfer: when resident utilizes wheelchair and is unable to propel self and needs assistance to be pushed then leg rest should be on wheelchair and for all transports out of facility leg rest should be utilized, initiated 8/30/24.</p> <p>The Progress Notes included, but were not limited to:</p> <p>On 8/28/24 at 6:20 a.m., Late entry: CNA reported that resident was complaining of pain to left foot when care was being provided. Upon assessment no swelling/bruising/redness noted. When foot touched and moved resident stated, Ow that hurts. This nurse inquired as to what had happened and resident stated, My foot went under the wheelchair earlier. It's no big deal it just hurts when it is moved some. I am going to see if it feels better later today. This nurse passed information on in report to dayshift to monitor foot for any changes.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155621	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/10/2024
NAME OF PROVIDER OR SUPPLIER  River Bend Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  3400 Stocker Dr Evansville, IN 47720	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/28/24 at 12:23 p.m., physicians order note, This morning, resident reported pain to left foot/ankle secondary to injury that occurred while out on appointment yesterday afternoon. Upon speaking with staff, learned that while out for afternoon appointment, resident did not have foot pedals on wheelchair and while propelling resident along sidewalk, her foot became stuck under chair at a backwards angle. Upon observation, noted swelling and faint bruising to left foot and ankle. Resident guarding when area is lightly palpated. Resident placed on non-weight bearing status and NHT (Nursing Home Triage) notified. Will obtain xray of left foot and ankle upon return from dialysis today.</p> <p>On 8/29/24 at 1:48 p.m., Residents x-ray to left foot and ankle came back positive for fracture. Notified NHT and made aware. Stated it was residents choice to got to emergency room or Ortho in the morning. Resident chose to got to Ortho urgent care in the morning. Notified ADON (Assistant Director of Nursing).</p> <p>On 8/29/24 2:31 p.m., Resident returned from appointment with order to have splint placed to left foot/ankle. Requires resident to go back to Ortho to have splint fitted. Rehabilitation Director came to unit to apply brace for stabilization until fitted for splint.</p> <p>On 8/29/24 at 4:37 p.m., Call made to residents daughter to inform that resident was in route to hospital due to fall in wheelchair van from wheelchair to floor of van.</p> <p>On 8/29/24 at 6:15 p.m., received call from hospital reporting resident had a mild right ankle fracture and will be sent back to facility tonight. DON notified and daughter updated.</p> <p>On 8/30/24 at 11:02 a.m., Spoke with resident this morning regarding pain for BLE (bilateral lower extremity) fractures. Resident did not make it to Ortho Urgent Care yesterday in order to have splint placed to left foot/ankle due to fall in transport van subsequent emergency department visit. Resident resting in bed at this time with the boot ortho therapy placed yesterday still in place to left lower extremity, right foot/ankle with Ace wrap in place from emergency department visit.</p> <p>On 9/5/24 at 1:27 p.m., Splint in place to left lower extremity this morning. Toes warm. Ace bandage wrap in place to right foot/ankle. Complaints of pain to bilateral lower extremities. As needed pain medication given per order and was effective.</p> <p>A Physical Therapy Note, date of services 6/25/24 through 8/26/24, indicated wheelchair mobility supervision or touching assistance for wheel 150 feet.</p> <p>The investigation to the state reportable's was reviewed on 9/10/24 at 9:00 a.m., and included but was not limited to the following statements and radiology reports.</p> <p>A statement dated 8/29/24 signed by the DON:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155621	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/10/2024
NAME OF PROVIDER OR SUPPLIER  River Bend Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  3400 Stocker Dr Evansville, IN 47720	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Approximal [sic] 330pm [3:30 p.m.], the Administrator received a phone call from the Van driver indicating he needed help with [Resident B] related to her sliding out of the wheelchair into the van floor while riding back to the facility from a scheduled appointment. I went with multiple staff members to assist in getting the resident back to her wheelchair. Upon arrival [Resident B] was complaining of right ankle pain. Her right foot was bent to the right against the passenger side seat. She was sitting upright on the van floor with her back against bilateral foot pedals. EMS [emergency medical service] was called to transport to the hospital for evaluation. I spoke to the van driver to determine how resident was able to slide out of the wheelchair, he indicated he did not have the seat belt secured correctly. When I asked why he didn't secure the seatbelt correctly, I (sic) said I am not sure.</p> <p>A statement, dated 8/29/24, signed by the van driver:</p> <p>I took Ms [Resident B] to an appointment at [name of facility] at the pain clinic/Oncologist [sic], on my way up to the door her foot slipped under the chair and bent, sole up to the air. I stopped then and realized she didn't have her Foot [sic] rest on the chair. Every time before this incident she has always had her foot rest on. So when I Took [sic] her from her room, since they told me she was ready I took her out and didn't realize they weren't installed on there.</p> <p>A statement, dated 8/30/24, signed by the van driver</p> <p>I transported Ms [Resident B] to [name of facility] in [name of city] got there I got told that was was the wrong one. While I was still there I asked one of the Physical Therapist if he would help me pull her up in the wheelchair. He helped me, as we progressed to the right one, she started to slide again slowly. I thought she was safe with her seat belt on, I took all the slack out of the belt, but when made it to [name] exit she was 3/4's way out of her chair. The she said to just bring her back Nobody should have to ride like this she said. When I got to [name of street] and [name of street] she had completely slipped out of her chair. I pulled over at [name of store] To call [Administrator], to which he told me the nurses to meet me to help me get her out In the chair. When they arrived they attempted to get her back in the chair, but had to call 911 to get the EMT's [Emergency Medical Technicians] help and they took her to the hospital.</p> <p>A radiology report for the left ankle with an examination date and time of 8/28/24 4:49 p.m., included but was not limited to:</p> <p>Impression:</p> <ol style="list-style-type: none"> <li>1. Acute nondisplaced oblique (slanted) coronal fracture through the lateral malleolus (bone on the outside of the ankle joint).</li> <li>2. No joint subluxation or dislocation seen.</li> <li>3. Severe diffuse osteopenia.</li> </ol> <p>A radiology final report for the right ankle with a created date of 8/29/24 at 10:08 p.m., provided by the DON on 9/9/24 at 11:47 a.m., included, but was not limited to:</p> <p>Impression: 1. The study is somewhat limited secondary to suboptimal positioning.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155621	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/10/2024
NAME OF PROVIDER OR SUPPLIER  River Bend Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  3400 Stocker Dr Evansville, IN 47720	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>There appears to be a minimally displaced fracture through the lateral malleolus. No dislocation is seen.</p> <p>A second radiology final report for the right ankle provided by the Administrator on 9/10/24, time unknown, had a created date of 8/29/24 at 6:05 p.m., and include, but was not limited to:</p> <p>Findings: No acute fracture, dislocation, or radiopaque foreign body.</p> <p>On 9/10/24 at 12:01 p.m., the Administrator indicated at the time of the first incident Resident B self-propelled herself in the wheelchair.</p> <p>On 9/10/24 at 12:30 p.m., Resident B indicated staff mostly push her in her wheelchair when she is out to appointments, she was not able to, foot rests were on most of the time, it was chaotic in her room before she left the facility on the day of the first incident, there were five to six people in her room, and the foot rests were forgotten. Resident B indicated the second day when she slid out of her chair, the driver did not buckle her in, he did not put the seat belt on her, only strapped the legs of the wheelchair. Resident B indicated the driver laughed and asked her if she wanted him to strap her in, she said if he didn't want to put it on then don't, and he didn't.</p> <p>On 9/10/24 at 1:33 p.m., the Administrator provided the current resident transport policy with a revised date of August 2023. The policy included, but was not limited to: . All passengers must wear a seat belt, wheelchair passengers must have wheelchairs secured to van. Make sure the attachment straps are attached over the frame of the wheelchair. Residents must be securely restrained to the wheelchair .</p> <p>On 9/10/24 at 1:33 p.m., the Administrator provided the current policy on transporting a resident via wheelchair with a adopted policy date of 8/29/24. The policy included, but was not limited to: Residents who are unable to ambulate short or long distances either independently or with the assistance of staff will utilize a wheelchair for mobility. For safety purposes residents will not be transported (pushed) in wheelchairs without the use of leg rests. Guidelines: 1. If the resident is able to self-propel the wheelchair footrests may be off. However, if the resident is unable to propel the wheelchair- foot rests will be utilized .2. c. Always ensure proper positioning of the resident in the chair (sitting properly) to avoid falls .e. Always be alert and attentive to the resident for things- such as leaning forward or abruptly placing feet on floor -to prevent falls from wheelchair</p> <p>This deficient practice was corrected on 8/31/24 after the facility implemented a systemic plan of correction that included the following actions: all transportation staff was educated on safe transfers with return demonstrations, staff was educated on the facility wheelchair policy, staff was educated on abuse policy, with ongoing monitoring and audits.</p> <p>This citation relates to Complaint IN00437526.</p> <p>3.1-45(a)(2)</p>		