STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155621	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Bend Nursing and Rehabilitation	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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to notify a resident's emergency contact of an injury and subsequent x-ray order in 1 of 3 residents reviewed for falls. (Resident B)Finding includes:On 11/24/25 at 9:54 A.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, age-related osteoporosis, and protein-calorie malnutrition.The most current Quarterly Minimum Data Set (MDS) Assessment, dated 8/12/25, indicated that Resident B was not assessed for cognitive function because she was rarely or never understood, was dependent on staff for transfers and toileting, required partial to moderate assistance of staff (staff does less than half of the effort) for eating, had no falls since in the prior assessment, and weighed 104 pounds (lbs) with no significant weight loss.Physician orders included but were not limited to:May obtain 4 views of right knee for pain and swelling, dated 9/4/25An incident note, dated 8/30/25 at 1:15 A.M., indicated Resident B was found on the floor on her fall mat. An assessment was completed with no injuries noted.A health status note, dated 9/3/25 at 10:41 P.M., indicated Resident B was noted to have swelling and tenderness to her inner right thigh just above her knee. Nursing Home Triage (NHT) was notified.A nursing note, dated 9/4/25 at 5:05 P.M., indicated an order was received for a 4-view x-ray of Resident B's right knee.An incident note, dated 9/5/25 at 4:20 P.M., indicated that (name of mobile x-ray company) was in the facility to obtain the 4-view x-ray of Resident B's right knee.The clinical record, including progress notes and events dated 9/3/25 at 10:41 P.M. to 9/5/25 at 4:20 P.M., lacked documentation to indicate Resident B's emergency contact was notified of the new injury or that an x-ray had been ordered.During an interview on 11/24/25 at 3:36 P.M., a family member indicated he was not notified of the new injury or that an x-ray had been ordered until after the resident had an order to be sent to the emergency room (ER).During an interview on 11/25/25 at 8:55 A.M., the Director of Nursing (DON) indicated that the emergency contact should have been notified about the resident's initial x-ray order.On 11/25/25 at 10:52 A.M., the Administrator provided a current Change in a Resident's Condition or Status policy, revised October 2010, that indicated Our facility shall promptly notify the .representative (sponsor) of changes in the resident's medical/mental condition and/or status . the Nurse Supervisor/Charge Nurse will notify the resident's responsible party of family when: a. The resident is involved in any accident or incident that results in an injury including injuries of an unknown source .The citation relates to intake 2615764.3.1-5(a)(2)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure physician orders were followed for 1 of 3 residents reviewed for falls and weight loss. An x-ray of an emergent injury was delayed 24-hours and weekly weights were not completed as ordered. (Resident B)Findings include:On 11/24/25 at 9:54 A.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, age-related osteoporosis, and protein-calorie malnutrition.The most current Quarterly Minimum Data Set (MDS) Assessment, dated 8/12/25, indicated Resident B was not assessed for cognitive function because the resident was rarely or never understood. Resident B was dependent on staff for transfers and toileting, required partial to moderate assistance of staff (staff does less than half of the effort) for eating, had no falls since the prior assessment, and weighed 104 pounds (lbs) with no significant weight loss.A. Physician orders included, but were not limited to:May obtain 4 views of right knee for pain and swelling, dated 9/4/25 at 4:37 P.M.STAT: May obtain 4 views of right knee for pain and swelling, dated 9/5/25 at 12:10 P.M.An incident note, dated 8/30/25 at 1:15 A.M., indicated Resident B was found on the floor on her fall mat. An assessment was completed with no injuries noted.Follow-up fall and pain assessments, dated from 8/30/25 through 9/3/25 at 10:41 P.M., indicated no injury or pain was noted.A health status note, dated 9/3/25 at 10:41 P.M., indicated Resident B was noted to have swelling and tenderness to her inner right thigh just above her knee. Nursing Home Triage (NHT) was notified.NHT call logs indicated that on 9/4/25 at 7:11 A.M., Nurse Practitioner (NP) 15 gave orders to NHT to obtain a 4-view x-ray of Resident B's right knee.NHT call logs indicated that on 9/4/25 at 9:16 A.M., NHT gave orders to Licensed Practical Nurse (LPN) 8 to obtain a 4-view x-ray of Resident B's right knee.A nursing note, dated 9/4/25 at 5:05 P.M., indicated an order was received for a 4-view x-ray of Resident B's right knee. The order was called in to (name of mobile x-ray company).A health status note, dated 9/4/25 at 7:40 P.M., indicated that (name of mobile x-ray company) called to confirm the x-ray order and said someone would be out in the morning to complete the x-ray. The resident's right knee and thigh was noted to have swelling and scattered bruising with no signs or symptoms of pain or discomfort.A nursing note, dated 9/5/25 at 11:40 A.M., indicated staff were transferring Resident B to her wheelchair for lunch using a mechanical lift when staff noticed the resident's right upper extremity was bruised and the right lower extremity was swollen and bruised, was warm to the touch, and appeared to be distorted. NHT was notified and a STAT order for 4-view of right knee was requested.An incident note, dated 9/5/25 at 4:20 P.M., indicated that (name of mobile x-ray company) was in the facility to obtain a 4-view x-ray of Resident B's right knee. The resident's right femur was broken. An order was received to send Resident B to the emergency room for evaluation and treatment. A health status note, dated 9/5/25 at 5:47 P.M., indicated that the resident had been transported to the hospital via ambulance.A hospital Discharge summary, dated [DATE] at 5:46 P.M., indicated that on 9/3/25 the resident developed swelling and pain on the sole of the right knee and an x-ray was ordered, but not obtained. During an interview on 11/25/25 at 8:55 A.M., the Director of Nursing (DON) indicated that she was unsure why LPN 8 waited eight hours to put in the order for the x-ray and notify (name of mobile x-ray company) of the order, and that orders should be put in upon receipt of the order.On 11/25/25 at 9:46 A.M., the DON provided an agenda for a license nursing meeting, dated 9/9/25, that indicated orders for x-rays are to be written when received and (name of mobile x-ray company) notified of the order. If (name of mobile x-ray company) is unable to obtain the x-ray in a timely manner, call NHT to obtain orders to transfer out to the hospital for x-ray to prevent a delay in care and treatment.On 11/25/25 at 9:46 A.M., the DON provided an Assessing Falls and Their Causes policy, revised March 2018, that indicated If there is evidence of injury, provide appropriate first aid and/or obtain medical treatment immediately.B. Physician orders included, but were not limited to:Weekly weight - every day shift every Tuesday for monitoring per dietician, dated 11/26/24A current risk for altered nutritional / hydration status care (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan, revised 2/19/25, included an intervention to monitor weights.A current nutritionally at risk care plan, revised 8/3/24, included an intervention to record and monitor weights.A health status note, dated 11/26/24 at 6:04 A.M., indicated Nurse Practitioner (NP) 2 was notified of a significant weight loss. NP 2 gave an order for the resident to be weighed weekly.An Interdisciplinary Team (IDT) note, dated 3/5/25 at 2:28 P.M., indicated that Resident B had 10% weight loss over 180 days. It was noted that the scales had been down for several weeks in the past possibly attributing to the weight loss.The Treatment Administration Record (TAR) from 12/1/24 to 9/2/25 was reviewed. The TAR indicated that weekly weights had been completed. The TAR lacked documentation to indicate what the weights were.The Weights and Vitals Summary from 12/1/24 to 9/2/25 was reviewed. The following dates lacked a recorded weight:12/312/1712/2412/311/211/282/112/182/253/183/254/14/84/224/295/205/276/106/176/247/17/157/227 an interview on 11/24/25 at 11:43 A.M., the Director of Nursing (DON) indicated that staff should put weights into the Weights and Vitals section of the electronic medication record (EMR). If the weights were not there, they were not done, and staff were probably checking off that they had completed it but hadn't actually done it.On 11/25/25 at 10:52 A.M., the DON provided a Weight Assessment and Intervention policy, revised March 2019, that indicated Weights will be recorded in each individual's medical record.The citation relates to intake 2615764.3.1-35(g)(1)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure alternative supplements were provided to accommodate a resident's allergies. (Resident D) Findings include:On 11/24/25 at 10:48 A.M., Resident D's clinical record was reviewed. Resident D was admitted on [DATE]. Diagnoses included, but were not limited to, Type 2 Diabetes Mellitus.The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 11/18/25, indicated Resident D was severely cognitively impaired and completely dependent on staff (staff do more than half of the work) for eating, bathing, toileting, and transfers.Resident D's allergy list included, but was not limited to, milk and milk related products. Current physician orders included, but were not limited to:MedPass 2.0 (a dietary supplement) one time a day for weight; Start date 10/29/25A Registered Dietitian progress note, dated 10/2/25 at 10:39 A.M., indicated Resident D should not consume milk or milk related compounds due to a hives reaction, to consider this a true milk protein allergy, and for dietary staff to make Resident D's tray separately. During an observation on 11/25/25 at 8:36 A.M., LPN 8 indicated Resident D received MedPass 2.0 supplement daily with morning medications, and pointed out the carton of Med Pass 2.0. The first ingredient in MedPass 2.0 indicated milk as the first ingredient and a bold warning of contains milk. During an interview on 11/25/25 at 9:41 A.M., the Director of Nursing (DON) indicated Resident D should not be receiving a supplement that contained milk. On 11/25/25 at 10:52 A.M., the Administrator provided a policy titled Food Allergy and Intolerance, dated 7/23, that indicated Resident with food intolerances and allergies are offered appropriate substitutions for foods they can not eat.The citation relates to intake 2615764.