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	07/01/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to notify the physician of a change of health condition for 1 of 3 residents reviewed. The physician was not notified of new skin impairment. (Resident D) Finding includes: On 6/30/26 at 10:52 a.m., Resident D was interviewed and indicated he had skin impairment to his bottom.On 6/30/26 at 1:11 p.m., Resident D's clinical record was reviewed. Diagnoses included but were not limited to, hypertension, tobacco use, morbid (severe) obesity due to excess calories, localized edema, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, unspecified atherosclerosis of native arteries of extremities, bilateral legs, peripheral vascular disease, unspecified, type 2 diabetes, chronic diastolic (congestive) heart failure. A quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated Resident D's cognition was intact. Care plans were reviewed and included but were not limited to:The resident is at risk for pressure ulcers due to weakness, hx (history) of CVA (cerebrovascular accident) date initiated 8/6/19, revision 2/20/20, target date 10/3/26. Interventions included but were not limited to: perform weekly skin checks and document, inform resident/MD/family/caregivers of any new aea of skin breakdown, date initiated 8/6/19. Actual/potential for skin integrity impairment r/t (related to) chronic progressive disease, friction, lack of sensation, mobility deficit, obesity, date initiated 7/1/21, revision 2/2/22, target date 7/4/26. Interventions included but were not limited to: Monitor and report any reddened areas to MD (medical doctor), Document on flow sheet: if skin is intact, mark Y. If skin is reddened or has open areas, mark N. Report any new openings to Registered staff, date initiated 7/1/21. Orders were reviewed and included but were not limited to: Weekly skin assessment every night shift every Tues, order date 5/27/26. Triad hydrophilic wound dress external paste (wound dressing) apply to bilateral buttocks topically every shift for MASD (moisture associated skin damage) cleanse with wound cleanser, pat dry, apply paste and leave open to air, order date 1/22/26. Triad hydrophilic wound dress external paste (wound dressings) apply to bilateral buttocks topically as needed for soilage. Cleanse with wound cleanser, pat dry, apply triad paste and leave open to air, order date 1/22/26. Weekly skin assessment forms were reviewed from 3/12/26- 7/1/26. 3/12/26 - Skin condition: open area, pre- existing. Site: coccyx. Description: Pre existing open area to sacrum, tx (treatment) q (every) shift with Triad , wound NP (Nurse Practitioner) follows weekly. 4/3/26- Skin condition: open area. Other: pre- existing open area to sacrum, tx q shift with Triad, wound NP follows weekly.6/1/26- Skin condition: Dry, pre-existing , redness. Other: Reddened areas to buttocks, treatment in place. No open areas at this time. 6/3/26- Skin condition: Skin intact, pre-existing redness. Other: buttocks with treatment in place. 6/5/26- Other: Has pre-existing shallow open areas to buttocks that already have treatments ordered, otherwise no new areas noted. 6/10/26- Skin condition: Pre-existing open area. Other: Small areas to buttocks with tx in place and is effective. Pt (patient) denies pain to areas. Site: Right buttock- small area, Left buttock- small area.6/24/26- Skin condition: Redness. Other: L (left) thumb next to nail has pus filled pocket. Seen by NP today, topical et, oral antibiotics ordered. 7/1/26-Other: L. thumb, continues oral and topical ABT(antibiotics) as ordered. The form did not document the skin impairment observed to the bilateral buttocks and coccyx (continued on next page)

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

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(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	on 7/1/26 at 1:20 p.m. The above dates were the only skin assessment forms in the clinical record from 3/12/26- 7/1/26. The TAR (Treatment Administration Record) was initialed for weekly skin assessments completed. A wound NP skin assessment form with a visit date of 3/10/26 at 10:00 a.m., was reviewed and included but was not limited to the following: Wound #1 - Upon examination, the Right buttock MASD shows complete epithelialization with no signs of infection or inflammation. Healing is complete, and the wound is now fully closed. Education/Plan: Education provided to: nursing staff, patient.A progress note dated 3/10/26 at 11: 31 a.m. indicated Resident was seen by wound care NP [name] n(sic) 3-10-26, wound #1 right buttock shows complete epithelialization with no signs of infection or inflammation. Healing is complete, wound is fully closed. On 7/1/26 at 10:56 a.m., the DON indicated the wound NP comes in once a week on Thursdays, the last date Resident D was seen was on 3/10/26 and the NP indicated his skin was healed. If a new skin area is found by staff it is reported to the DON, area is measured, it is reported to the wound NP and the regular NP, the DON should have been told by staff of any open areas to Resident D's skin. On 7/1/26 at 1:17 p.m., the DON indicated the only forms found for weekly skin assessments were what was in the clinical record, forms should be filled out weekly for skin assessments. At 1:20 p.m., the DON was observed to measure Resident D's skin areas to his buttocks and coccyx. The DON indicated the following for the assessment: Left buttock: L(length) 4 cm(centimeter) x W (width) 4 cm, red area , not open Right buttock: L 5.5 cm x W 5.4 cm, red area, open area in center L 1 cm x W .5 cm. Coccyx: circular red area 4 cm x 3 cm. Reddened area above circular area to coccyx: L 3 cm x W 4.5 am.On 7/1/26 at 2:07 p.m., RN 2 indicated the nurse does weekly skin assessments, are supposed to document findings on a form in PCC (Point Click Care), put initials on the MAR (Medication Administration Form). If a new open area is found measurements are taken, the DON, doctor, and family are notified. If a new order is given it is put in the orders. On 7/1/26 at 2:25 p.m., the Administrator provided the current policy on notification of changes with a revision date of 2025. The policy included but was not limited to: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification .3.Circumstances that require a need to alter treatment. This may include: a. New treatment, b. Discontinuation of current treatment due to: i. Adverse consequences. ii. Acute condition. iii. Exacerbation of a chronic condition .a. The facility must still contact the resident's physician and notify resident's representative, if known .This citation relates to Intake 3027544 and 3006524. 410 IAC (Indiana Administrative Code) 3.1-5(a)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain complete and accurate medical records; skin assessment forms were not documented weekly in the clinical record, did not include all of the current skin impairments for 1 of 3 residents reviewed for nursing services. (Resident D) Finding includes: On 6/30/26 at 10:52 a.m., Resident D was interviewed and indicated he had skin impairment to his bottom.On 6/30/26 at 1:11 p.m., Resident D's clinical record was reviewed. Diagnoses included but were not limited to, hypertension, tobacco use, morbid (severe) obesity due to excess calories, localized edema, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, unspecified atherosclerosis of native arteries of extremities, bilateral legs, peripheral vascular disease, unspecified, type 2 diabetes, chronic diastolic (congestive) heart failure. A quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated Resident D's cognition was intact. Care plans were reviewed and included but were not limited to:The resident is at risk for pressure ulcers due to weakness, hx (history) of CVA (cerebrovascular accident) date initiated 8/6/19, revision 2/20/20, target date 10/3/26. Interventions included but were not limited to: perform weekly skin checks and document, inform resident/MD/family/caregivers of any new aea of skin breakdown, date initiated 8/6/19. Actual/potential for skin integrity impairment r/t (related to) chronic progressive disease, friction, lack of sensation, mobility deficit, obesity, date initiated 7/1/21, revision 2/2/22, target date 7/4/26. Interventions included but were not limited to: Monitor and report any reddened areas to MD (medical doctor), Document on flow sheet: if skin is intact, mark Y. If skin is reddened or has open areas, mark N. Report any new openings to Registered staff, date initiated 7/1/21. Orders were reviewed and included but were not limited to: Weekly skin assessment every night shift every Tues, order date 5/27/26. Triad hydrophilic wound dress external paste (wound dressing) apply to bilateral buttocks topically every shift for MASD (moisture associated skin damage) cleanse with wound cleanser, pat dry, apply paste and leave open to air, order date 1/22/26. Triad hydrophilic wound dress external paste (wound dressings) apply to bilateral buttocks topically as needed for soilage. Cleanse with wound cleanser, pat dry, apply triad paste and leave open to air, order date 1/22/26. Weekly skin assessment forms were reviewed from 3/12/26 - 7/1/26.3/12/26 - Skin condition: open area, pre- existing. Site: coccyx. Description: Pre existing open area to sacrum, tx (treatment) q (every) shift with Triad , wound NP (Nurse Practitioner) follows weekly. 4/3/26- Skin condition: open area. Other: pre- existing open area to sacrum, tx q shift with Triad, wound NP follows weekly.6/1/26- Skin condition: Dry, pre-existing , redness. Other: Reddened areas to buttocks, treatment in place. No open areas at this time. 6/3/26- Skin condition: Skin intact, pre-existing redness. Other: buttocks with treatment in place. 6/5/26- Other: Has pre-existing shallow open areas to buttocks that already have treatments ordered,otherwise no new areas noted. 6/10/26- Skin condition: Pre-existing open area. Other: Small areas to buttocks with tx in place and is effective. Pt (patient) denies pain to areas. Site: Right buttock- small area, Left buttock- small area.6/24/26- Skin condition: Redness. Other: L (left) thumb next to nail has pus filled pocket. Seen by NP today, topical et, oral antibiotics ordered. 7/1/26-Other: L. thumb, continues oral and topical ABT(antibiotics) as ordered. The form did not document the skin impairment observed to the bilateral buttocks and coccyx on 7/1/26 at 1:20 p.m. The above dates were the only skin assessment forms in the clinical record from 3/12/26- 7/1/26. The TAR (Treatment Administration Record) was initialed for weekly skin assessments completed. A wound NP skin assessment form with a visit date of 3/10/26 at 10:00 a.m., was reviewed and included but was not limited to the following: Wound #1 - Upon examination, the Right buttock MASD shows complete epithelialization with no signs of infection or inflammation. Healing is complete, and the wound is now fully closed. Education/Plan: Education provided to: nursing staff, patient.A progress note dated 3/10/26 at 11: 31 a.m. indicated Resident was seen by (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound care NP [name] n(sic) 3-10-26, wound #1 right buttock shows complete epithelialization with no signs of infection or inflammation. Healing is complete, wound is fully closed. On 7/1/26 at 10:56 a.m., the DON indicated the wound NP comes in once a week on Thursdays, the last date Resident D was seen was on 3/10/26 and the NP indicated his skin was healed. If a new skin area is found by staff it is reported to the DON, area is measured, it is reported to the wound NP and the regular NP, the DON should have been told by staff of any open areas to Resident D's skin. On 7/1/26 at 1:17 p.m., the DON indicated the only forms found for weekly skin assessments were what was in the clinical record, forms should be filled out weekly for skin assessments. At 1:20 p.m., the DON was observed to measure Resident D's skin areas to his buttocks and coccyx. The DON indicated the following for the assessment: Left buttock: L(length) 4 cm(centimeter) x W (width) 4 cm, red area , not open Right buttock: L 5.5 cm x W 5.4 cm, red area, open area in center L 1 cm x W .5 cm. Coccyx: circular red area 4 cm x 3 cm. Reddened area above circular area to coccyx: L 3 cm x W 4.5 am.On 7/1/26 at 2:07 p.m., RN 2 indicated the nurse does weekly skin assessments, are supposed to document findings on a form in PCC (Point Click Care), put initials on the MAR (Medication Administration Form). If a new open area is found measurements are taken, the DON, doctor, and family are notified. If a new order is given it is put in the orders. On 7/1/26 at 2:25 p.m., the Administrator provided the current policy on documentation of wound treatments with a revision date of 2025. The policy included but was not limited to: The facility completes accurate documentation of wound assessments and treatments, including response to treatment, change in condition, and changes to treatment. 1. Wound assessments are documented on admission, weekly, and as needed if the resident or wound condition deteriorates. 2. The following elements are documented as part of a complete wound assessment: a. Type of wound (pressure injury, surgical, etc.) and anatomical location .c. measurements: height, width, depth, underming, tunneling. d. description of wound characteristics . 4. additional documentation shall include, but it not limited to: .notifications to physician and/or responsible party regarding wound or treatment changes On 7/1/26 at 2:25 p.m., the Administrator provided the current policy for skin and wound management with a revision date of September 2022. The policy included but was not limited to: It is the policy of this center's Skin Management System to identify and assess residents with wounds and/or pressure ulcers, as well as those at risk for skin compromise. Such residents are then provided appropriate treatment to encourage healing, and/or integrity. Ongoing monitoring and evaluation are then provided to ensure optimal resident outcome .3. Ongoing weekly evaluations of resident's skin will completed and documented in PCC on the Weekly Skin Evaluation form .This citation relates to Intake 3027544 and 3006524. 410 IAC (Indiana Administrative Code) 3.1-50(a)(1)410 IAC (Indiana Administrative Code) 3.1-50(a)(2)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a safe, sanitary, and homelike environment for residents who resided in the facility for 1 of 2 units observed. Baseboards, walls, door trim on resident rooms were marred or had chipped paint, floors had debris built up. (200 unit) Findings include: On 7/1/26 at 9: 40 a.m., the following was observed on the 200 unit:Walls on the unit hallways were marred. room [ROOM NUMBER] had a large hole in the wall by the foot of the bed. The wall by the offices had a large chunk of drywall missing. Dirt build up around baseboards.Door trim around resident rooms were marred or had chipped paint.Floors on the hallways had dirt buildup in corners and around the double doors on the unit. The floor in the dining room had debris build up around baseboards and in corners.The elevator floor had dirt build up around the edges of the walls. The wrap around the elevator door frame outside of the elevator doors, was hanging/coming off on both sides. On 7/1/26 at 2:13 p.m., Housekeeper 3 indicated the floor technician recently got let go, the facility was down a housekeeper, floors should be cleaned daily. On 7/1/26 at 2:25 p.m., the Administrator provided the current policy on safe and homelike environment with a copyright date of 2025. The policy included but was not limited to: In accordance with resident's rights, the facility will provide a safe, clean, comfortable and homelike environment .410 IAC (Indiana Administrative Code) 16.2-3.1-19(f)