STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155849	A. BUILDING 00 B. WING	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVER TERRACE HEALTH CAMPUS	120 PRESBYTERIAN AVE MADISON, IN 47250

(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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00454644. Complaint IN00454644 - Federal/State deficiencies related to the allegations are cited a F677, F697 and F725. Survey dates: March 26 and 28, 2025 Facility number: 013535 Provider number: 155849 AIM number: 300018660 Census Bed Type: SNF/NF: 41 Residential: 27 Total: 68 Census Payor Type: Medicare: 18 Medicaid: 16 Other: 7 Total: 41 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 2, 2025.	F 0000	This submission of the plan of correction does not indicate an admission by River Terrace Health Campus that the findings and allegations contained herein are accurate and true representations of the care and services provided to the residents of River Terrace Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility herein maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. (for Title 18/19 programs). Attached you will find our Plan of Correction for River Terrace Health Campus for our annual survey conducted on March 28, 2025. We initiated immediate interventions when concerns were identified on this date. We respectfully request desk review for this plan of correction. If you need any information or paperwork, please do not hesitate to contact us at (812) 265-0080. Sincerely, Rhonda Gibson, Executive Director	
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rhonda Gibson	Executive Director	04/19/2025

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.

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	Based on interview and record review, the facility failed to provide activities of daily living (ADL) related to incontence care and personal assistance for 4 of 5 residents reviewed for ADL care. (Residents E, D, G, and C) Findings include: 1. During an interview, on 3/26/25 at 8:03 p.m., Resident E indicated she had turned her call light on for assistance to go to the bathroom and the Certified Nurse Aide (CNA) indicated she was the only one on the floor and could not help her. The resident was advised the facility did not have a walker or wheelchair for her to use at that time. After waiting over an hour the resident contacted her family member at home. The resident's family member indicated the resident called him and asked him to come and get her help. The clinical record for Resident E was reviewed on 03/28/25 at 11:07 a.m. The resident's diagnoses included, but were not limited to, femur fracture, Type 2 diabetes mellitus, diverticulosis, and hypertension. During a confidential interview, from 3/26/25 through 3/28/25, Staff 12 indicated it was very hard to care for the residents when you were the only one on the hallway. The extra wheelchairs, walkers, and bed side commodes were in the basement, and you could not leave the floor without any staff to gather the supplies. 2. During an interview and observation, on 3/26/25 at 10:01 p.m., Resident D was observed sitting in her wheelchair on the right side of her bed. The resident had been sitting in the same position and location starting at 7:18 p.m. through 10:01 p.m. The resident indicated she had needed to go to	F 0677	**1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident E, D, G and C were affected by the alleged deficient practice. No adverse reactions were noted due to the deficient practice. 2 **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents who require assistance with toileting have the potential to be affected. The Director of Health Services (DHS) conducted an audit of all like residents, without any other deficiencies noted. Nursing staff who assist residents with toileting were in-serviced on facility toileting policy. **1.What measures will be put into place, and what systemic changes will be made to ensure the deficient practice does not occur?** As a measure of ongoing compliance, DHS or designee will audit 5 residents who require assistance with toileting to ensure proper toileting program is being used. Audits to be completed 3x/week x 4 weeks, weekly x 4 weeks, every other week x 4 weeks, and monthly x 3 months.	04/14/2025

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	the bathroom and did not know what to do or where to go. The resident's bilateral lower legs, ankles, and feet were swelling with edema (buildup of fluid in the tissues). The resident's call light was laying across the resident's bed approximately two feet from her wheelchair. During an interview on 3/26/25 at 10:07 p.m., CNA 3 indicated the day shift staff indicated they toileted the resident before they left their shift before 6:00 p.m. The resident was not toileted since day shift left. The current CNA from the other hallway and her were working their way around both sides of the hallway to toilet and place the residents in bed. They started on the other side of the floor and now are getting to Resident D's side of the building. An observation on 3/26/25 at 10:21 p.m., Resident D was provided toileting care. CNA 3 walked up to Resident D and indicated her legs were swollen and it would help when she laid down. CNA 3 and CNA 4 pushed Resident D's wheelchair into the bathroom area. CNA 4 walked back into the resident's bedroom area collected a gait belt from the resident's supplies on her bedside stand. The CNA opened the plastic wrap on the resident's gait belt and walked back into the bathroom. The resident was assisted to a standing position and the resident's soiled depend was removed. The resident had been slightly incontinent of bowel. The resident's buttocks and upper thighs were dark red with some deep purple areas. The CNA's placed the resident on the toilet and after a couple of minutes the resident's bottom was cleaned and she was dressed for bed. The clinical record for Resident D was reviewed on 03/28/25 at 10:00 A.M. The resident's diagnoses included, but were not limited to,		**1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement and will continue until 100% compliance is maintained.	

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	dementia, anxiety, hypertension, low back pain, chronic pain, weakness, disorientation, and insomnia. The Nursing Progress Note, dated 3/28/25 at 10:20 a.m., indicated Resident D was alert and oriented. The resident's speech was clear, and she was able to make her needs known. The resident had weakness and used a wheelchair for mobility. The resident's bilateral lower legs had no edema present. The resident was incontinent, and staff provided fall prevention and safety management. 3. During an interview and observation, on 3/26/25 at 7:16 p.m., Resident G indicated staff try to help, but they are working hard. He has had to wait from 20 to 40 minutes for a call light to be answered. Earlier today a staff member removed his empty water cup and indicated they would return with more water. After waiting over an hour and a half he never seen his water cup again and he was thirsty. The resident was observed to have no water cup or any other type of drink present in his room. At 7:42 p.m., the resident was observed to have received a cup of water by a staff member. The clinical record for Resident G was reviewed on 03/28/25 at 10:07 a.m. An Admission Minimal Data Set (MDS) assessment, dated 3/11/25, indicated the resident was alert and oriented. The resident required maximal assistance of staff and the use of a wheelchair for mobility. The resident's diagnoses included, but were not limited to, congestive heart failure, hypertension, peripheral vascular disease and renal failure. 4. During an interview and observation, on 3/26/25 at 7:12 p.m., Resident C was sitting in her bed. The resident had a nasal canula with oxygen being administered. CNA 3 indicated Resident C's			

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	oxygen tubing was not long enough to reach the bathroom and the resident had to go to the bathroom. She did not have a bed side commode and would have to go to the basement to get one. The resident's oxygen tubing was observed, and the tubing was not long enough to reach the bathroom. There was no bedside commode in the resident's room. During an observation, on 3/26/26 at 8:52 p.m., Resident C was apologizing to staff for being incontinent. There was no bedside commode in the resident's room. During an interview, on 3/26/25 at 10:47 p.m., the Administrator indicated they would get Resident C a longer oxygen tube to reach the restroom. She did not know why that had happened. Resident C was normally continent of bladder and bowel. The clinical record for Resident C was reviewed on 3/28/25 at 10:00 a.m. The resident's diagnoses include, but were not limited to, aspiration pneumonia, compression fracture of T5 and T6 vertebra, acute kidney failure, hypertensive heart disease with heart failure, asthma, and anemia. The Nursing Progress Note, dated 3/27/25, indicated the resident was alert and oriented. She was able to make her needs known. The resident required oxygen use and was continent and incontinent. During an observation, on 3/28/25, at 3:00 p.m., an associate staff member was in the bathroom with Resident C. The resident did not have any oxygen on and was assisted with a wheelchair back to her bedside chair. During an observation and interview, on 3/28/25			

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	at 4:18 p.m., Resident C indicated she was only half breathing and normally she wore oxygen. She continued to cough and puff as she was talking. The Resident Bladder Continence policy, dated 5/10/16 with a reviewed date of 12/17/24, indicated the purpose statement was "to provide measures for a resident who is incontinent to receive appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible..."...Toileting and continence interventions shall be communicated to care givers via the resident profile..." This citation relates to Complaint IN00454644. 3.1-38(a)(2)(C) 3.1-38(a)(2)(D)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management Based on record review and interview, the facility failed to ensure a resident's pain medication was administered timely after being requested for 1 of 3 residents reviewed for pain management. (Resident F) Findings Include: During an interview on 3/26/25 at 7:47 p.m., Resident F indicated he had waited for hours to receive pain pills, and it was the worst on evening shift. Once the pain increased so high it was hard for the medication to get control of the pain. The clinical record for Resident F was reviewed on 3/26/25 at 11:00 p.m., The resident's diagnoses included, but were not limited to, right femur	F 0697	F697 **1 What corrective action will be accomplished for those found to have been affected by the deficient practice?** Resident F was affected by the alleged deficient practice **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents who receive pain medications have the potential to be affected by the deficient	04/14/2025

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	fracture, chronic kidney disease, Type 2 diabetes mellitus, and anemia. The Nursing Progress note, dated 3/22/25 at 5:46 p.m., indicated the resident was alert and oriented. He required the extensive assistance of one staff member for transfers. He had a right hip fracture and incision. The resident rated his pain level a 6 out of 10 with a scale of 1 being the lowest and 10 being the highest pain level. The Nursing Progress note, dated 3/23/25 at 11:23 p.m., indicated the resident complained of having pain at a level of 6 out of 10. The Nursing Progress note, dated 3/24/25 at 4:18 a.m., indicated the resident's pain medication was administered as requested and effective. The resident requested his pain medication to be given at every six hours due to the pain becoming out of control if he waited. The Nursing Progress note, dated 3/24/25 at 9:27 p.m., indicated the resident complained of pain at a level of 6 out of 10 The Nursing Progress notes, dated 3/27/25 at 10:13 p.m., indicated the resident complained of having pain at a level of 6 out of 10. The physician's order, dated 3/22/25 through 3/29/25, indicated the resident was to receive hydrocodone 10/325 mg (milligrams) every six hours as needed for pain. The March 2025 Electronic Medication Administration Record (EMAR) indicated the resident received his hydrocodone 10/325 mg on the following days and times:		practice. The Director of Health Services (DHS) conducted an audit of all like residents, without any other deficiencies noted. Nursing staff who administer medications were in-serviced on facility pain medication administration policy. **3 What measures will be put into place, and what systemic changes will be made to ensure the deficient practice does not occur?** As a measure of ongoing compliance, DHS or designee will audit 5 residents who require pain medication for timely administration. Audits to be completed 3x/week x 4 weeks, weekly x 4 weeks, every other week x 4 weeks, and monthly x 3 months. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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	- On 3/22/25 at 8:15 p.m., the resident received his hydrocodone 10/235 mg (pain medication). - On 3/23/25 at 3:59 a.m. and 10:04 p.m., the resident received his pain medication. - On 3/24/25 at 3:54 a.m., 12:04 p.m., and 9:23 p.m., the resident received his pain medication. - On 3/25/25 at 3:12 p.m. and 8:57 p.m., the resident received his pain medication. - On 3/26/25 at 5:39 p.m., the resident received his pain medication. The March 2025 EMAR indicated the charted pain medication reasons and comments were documented as followed: - On 3/22/25 at 8:15 p.m., the resident's received his prn medication related to pain. - On 3/23/24 at 2:09 a.m., the resident's pain medication was effective. - On 3/23/25 at 3:59 a.m., the resident received his pain medication related to pain. - On 3/23/25 at 6:00 a.m., the resident's pain medication was effective. - On 3/24/25 at 12:43 p.m., the resident pain medication was somewhat effective. - On 3/26/25 at 9:34 p.m., the resident pain medication was effective. The physician's order, dated 3/22/25 through 3/25/25, indicated the staff were to monitor the resident's pain twice a day for 72 hours post admission. The March 2025 EMAR indicated the resident pain was monitored on the following days and times: - On 3/22/25 on the 6:00 p.m. to 10:00 p.m. shift, the resident rated his pain at a level 8 out of 10. - On 3/24/25 on the 6:00 a.m. to 10 :00 a.m. shift,			

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	the resident rated his pain at a level 0 out of 10. - On 3/24/25 on the 6:00 p.m. to 10:00 p.m. shift, the resident rated his pain at a level 7 out of 10. - On 3/25/25 on the 6:00 a.m. to 10:00 a.m. shift, the resident rated his pain at a level 0 out of 10. - On 3/25/25 on the 6:00 p.m. to 10:00 p.m. shift, the resident rated his pain at a level 7 out of 10. During an interview, on 3/26/25 at 7:28 p.m., QMA 6 indicated it was very hard to get your work completed and medications were sometimes administered late. The Pain Observation and Management policy, dated 5/11/16 with a reviewed date of 12/17/24, indicated "...initiate a plan of care related to chronic, acute or breakthrough pain...Evaluate the effectiveness of pain management interventions and modify as indicated..." The Specific Medication Administration Procedures policy, revised 11/18, indicated "...when administering an...(PRN) medication, document reason for giving, observe for medication actions/reactions and record efficacy..." This citation relates to Complaint IN00454644. 3.1-37(a)			
F 0725 SS=F Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff Based on observation, record review, and interview, the facility failed to ensure the facility was staffed to provide adequate care for the residents related to toileting and as needed pain medication. This deficient practice had the potential to affect 41 of 41 residents residing in	F 0725	**1 What corrective action will be accomplished for those found to have been affected by the deficient practice?** No residents were affected by this alleged deficient practice. 41 out	04/14/2025

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	the facility. Findings include: An observation of the 2nd floor 200 Hallways, on 3/26/25 at 7:08 p.m., indicated no staff were observed on the right-side Hallway of the 2nd floor. On the right-side Hallway of the 2nd floor five call lights were alarming, Resident H was lying on the floor in her room between her wheelchair and the bathroom doorway. The resident was yelling for help, and no staff were insight or within hearing distance. A staff member was located at 7:09 p.m. and notified of the resident lying on the floor yelling for help. The resident indicated to Certified Nurse Aide (CNA) 3 she had fallen and needed help. During an interview and observation, on 3/26/25 at 7:12 p.m., Resident C was sitting in her bed. The resident had a nasal canula with oxygen being administered. CNA 3 indicated Resident C's oxygen tubing was not long enough to reach the bathroom and the resident had to go to the bathroom. She did not have a bed side commode and would have to go to the basement to get one. At, 8:52 p.m., Resident C was apologizing to staff for being incontinent. There was no bedside commode in the resident's room or extension to the resident's oxygen tubing. During an interview, on 3/26/25 at 7:13 p.m., CNA 3 indicated she had not seen the nurse on her hallway for a while and did not know where she had gone. The CNA had been helping with a resident that required a full body mechanical lift on the other side of the 2nd floor. During an interview and observation, on 3/26/25 at 7:16 p.m., Resident G indicated staff would try		41 residents reviewed for toileting and pain medication administration without concern. **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All have the potential to be affected by the deficient practice. The Director of Health Services (DHS) conducted an audit of all residents, without any other deficiencies noted. Clinical scheduling reviewed and staffing patterns reviewed to ensure needs for toileting and as needed pain medications are adequate. IDT (interdisciplinary team) educated on staffing standards of practice. **3 What measures will be put into place, and what systemic changes will be made to ensure the deficient practice does not occur?** As a measure of ongoing compliance, ED or designee will randomly audit clinical schedule to ensure adequate staffing is adhered to including weekdays, weeknights, and weekends. Audits to be completed 3x/week x 4 weeks, weekly x 4 weeks, every other week x 4 weeks, and monthly x 3 months. **4 How the corrective**	

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	to help, but they were worked hard. He has had to wait from 20 to 40 minutes for a call light to be answered. Earlier today a staff member removed his empty water cup and indicated they would return with more water. After waiting over an hour and a half he never seen his water cup again and he was thirsty. During an interview, on 3/26/25 at 7:28 p.m., Qualified Medical Aide (QMA) 5 indicated it was very hard to get your work completed. There were residents that required two staff for mobility. Earlier a resident required a full body mechanical lift and the CNA from the other side of the 2nd floor had to come over to help. During an interview, on 3/26/25 at 8:03 p.m., Resident E indicated she had turned her call light on for assistance to go to the bathroom and the CNA indicated she was the only one on the floor and could not help her. The resident was advised the facility did not have a walker or wheelchair for her to use at that time. After waiting over an hour the resident contacted her family member at home. The resident's family member indicated the resident called him and asked him to come and get her help. During an interview on 3/26/25 at 8:14 p.m., RN 4 walked onto the hallway and answered one call light. At 8:15 p.m. the nurse walked past two of the other call lights. At 8:26 p.m., the nurse walked away from the hallway. At 8:28 p.m., the nurse returned and then walked to her medication cart. Then the nurse stood at her medication cart and was looking at the computer screen on the cart. She did not answer any of the three call lights alarming. At 8:29 p.m., the Clinical Support Nurse walked onto the hallway and answered one of the three call lights going off. At 8:30 p.m., the Clinical		**action(s) will be monitored to ensure the deficient practice will not recur?** As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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(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
	Support Nurse went into a second room and answered the resident's call light. At 8:38 p.m., the Administration Staff came and answered a resident's call light. At 9:24 p.m., the Administration Staff came back to the floor and answered another resident's call light that had been alarming. During an interview and observation, on 3/26/25 at 10:01 p.m., Resident D was observed sitting in her wheelchair on the right side of her bed. The resident had been sitting in the same position and location starting from 7:18 p.m. through 10:01 p.m. The resident indicated she had needed to go to the bathroom and has not seen any staff. She did not know what to do or where to go. During an interview, on 3/26/25 at 10:07 p.m., CNA 3, indicated the day shift staff had toileted Resident D before they left their shift. The day shift ended at 6:00 p.m. CNA 3 indicated the resident had not been toileted since the day shift left. During a confidential interview, from 3/26/25 through 3/28/25, Staff 12 indicated it was very hard to care for the residents when you were the only one on the hallway. The extra wheelchairs, walkers, and bed side commodes were in the basement, and you could not leave the floor without any staff to gather the supplies. During a confidential interview, from 3/26/25 through 3/28/25, Staff 13 indicated it was very hard to care for the residents when you were the only one on the hallway. On day shift some days residents did not receive their scheduled baths and, on the evening,/night shift it was the worst. The residents did not get toileted as often as they needed.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155849	A. BUILDING 00 B. WING	03/28/2025

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	During a confidential interview, from 3/26/25 through 3/28/25, Staff 14 indicated there were days she was not able to care for the resident like she wanted to. With three residents requiring a full body mechanical lift you had to find help to provide care. When you found help then it left no one to toilet the residents on the other side of the floor. Record review of the Facility Assessment Tool, dated 7/12/24, indicated the facility's resident profile had 18 rehab to home licensed beds and 39 long term care licensed beds. During an interview, on 03/28/24, the facility Administrator indicated they did not have a policy for staffing. Cross Reference F697: The facility failed to ensure a resident with complaints of pain received as needed pain medication in a timely manner. Cross Reference F677: The facility failed to ensure residents who were dependent on staff for activities of daily living received the care and services needed related to incontinence care. This citation relates to Complaint IN00454644. 3.1-17(a)			