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	01/22/2025

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey Dates: January 15, 16, 17, 21, and 22, 2025 Facility Number: 013535 Provider Number: 155849 AIM number: 300018660 Census Bed type: SNF/NF: 43 Residential: 29 Total: 72 Census payor type: Medicare: 21 Medicaid: 21 Other: 1 Total: 43 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on January 28, 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 January 22.2025. 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=D 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	02/06/2025

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, observation, and record review, the facility failed to ensure staff provided proper transfer techniques during transfers for 2 of 4 residents reviewed for activities of daily living. (Residents 183 and 14) Findings include: 1. During an observation on 1/15/25 at 9:13 a.m., Resident 183 was tearing up and moaning due to pain. He was unable to move his right shoulder and indicated he was in severe pain. The record for Resident 183 was reviewed on 1/17/25 at 10:24 a.m. The resident's diagnoses included, but were not limited to, primary osteoarthritis of the left shoulder, spinal stenosis, lumbar region without neurogenic claudication, and radiculopathy of the lumbar region. The Admission Minimum Data Set (MDS) assessment, dated 8/15/24, indicated the resident was cognitively intact. The resident required partial to moderate assistance for transferring safely. The care plan, dated 1/13/25, indicated Resident 183 had impairment in functional status related to weakness. The interventions included, but were not limited to, encourage the resident to be independent as safely as possible, provide assistance as needed with self-care and mobility functional tasks, therapy to evaluate and treat as needed and ordered. The nurse's note, dated 1/14/25 at 12:21 a.m., indicated the resident had continued complaints of right shoulder pain. The pain started the previous night when he was being transferred, per	F 0677	F677 **1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident #183 and #14 were affected by the deficient practice. Resident #183 is no longer a resident of the facility . Resident #14 deficient practice was corrected when the staff began utilizing a mechanical lift, no current deficient practice noted at this time. **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 transfers have the potential to be affected. The interim Director of Health Services (DHS) conducted an audit of all like residents, without any other deficiencies noted. All nursing staff who assist residents with transfers were in-serviced on facility transfer 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, Interim DHS or designee will audit 5 residents who require assistance with	02/09/2025

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	the resident. He was able to move without difficulty. He continued to use his right upper extremity when transferring and to push up from sitting position to standing. The resident was requesting an X-ray of his right shoulder. The nurse's note, dated 1/16/25 at 10:33 a.m., indicated the resident experienced weakness to his right upper extremity and complained of pain. The resident rated his pain level at a 6 to 8 on the 1 being the lowest to 10 being the highest pain scale in his right shoulder. The nurse's note, dated 1/17/25 at 3:30 p.m., indicated the resident spoke with the physician and requested an increase in his pain medication. A new order was received to discontinue the Norco 5-325 mg (milligram) and increase the Norco to 7.5-325 mg. During an interview and observation on 1/17/24 at 9:45 a.m., the resident was sitting up in his chair eating breakfast. He indicated he was still hurting, but not quite as bad if he didn't move his shoulder. During an interview on 1/17/24 at 1:15 p.m., Licensed Practical Nurse (LPN) 12 indicated staff should not be pulling residents by the arm. They should always use a gait belt to transfer the resident. It would be helpful if the facility provided more gait belts. There were a lot of new Certified Nursing Aides (CNAs), and they were still learning. During an interview on 1/21/24 at 8:15 a.m., RN 3 indicated the resident informed him a CNA had pulled him up by his arm and that was why he was having pain in his shoulder. The CNAs were supposed to transfer the residents with a gait belt		transfers to ensure proper transfer techniques are 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. **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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	and all the residents should have a gait belt in their rooms. 2. The record for Resident 14 was reviewed on 1/15/25 at 11:00 a.m. The resident's diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side; unspecified dementia; anxiety; cognitive communication deficit; and repeated falls. The Quarterly MDS assessment, dated 10/27/24, indicated the resident's cognition was severely impaired. The resident required maximal staff assistance with all ADL's (Activities of Daily Living). The care plan, dated 8/12/23, indicated the resident had impairment in functional status regarding bed mobility, transfers, toileting, and eating due to diagnosis of dementia. The interventions, dated 8/12/23, included, but were not limited to, encourage resident to be as independent as safely possible; dated 8/30/24, use a mechanical lift for transfers. A progress note, dated 8/30/2024 at 10:03 a.m., indicated the staff was giving Resident 14 a shower. The resident's shirt was removed, and bruising was observed under both arms. Bruising was observed to be from transfers and blood thinners. A Lift evaluation was completed, and the full body mechanical lift was to be used for all transfers. The Interdisciplinary Team (IDT) note, dated 8/30/24 at 12:23 p.m., indicated the resident was a two-person extensive assist for transfers. The resident presented with bruising under both arms congruent with staff lifting the resident under her arms. The resident was assessed and shook her			

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	head "no" when staff asked if she was hurting or was in any pain. The resident was ordered Eliquis and Aspirin and the physician was notified. A lift evaluation was completed. The resident was ordered to have a full body mechanical lift for transfers to avoid any further bruising of complications. The discharge summary from the hospital, dated 9/5/24, indicated that bruising was secondary to the resident taking a blood thinner and improper transfer at the extended care nursing facility. The care plan, dated 12/14/23, indicated the resident needed assistance with ADLs to assist with communication of the resident care needs. The interventions, dated 12/14/23, included, but were not limited to, transfers to be completed with a mechanical lift. During an interview on 1/16/25 at 9:30 a.m., RN 3 indicated the resident required the use of a full body mechanical lift for all transfers due to a history of bruising during transfers. During an interview with Certified Nursing Aide (CNA) on 1/17/25 at 10:30, the CNA indicated that it had been a long time since she had done a transfer. This resident was a two-person extensive assist prior to starting the use of the mechanical lift. The CNA indicated that two aides would transfer the resident from the bed to the chair by hooking their arms under the resident's armpits. The CNA did not indicate the use of a gait belt. During an interview on 1/17/25 at 1:24 p.m., CNA 5 indicated a gait belt was always used during a transfer. The Resident Transfer policy, dated 12/16/24,			

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	indicated ..."3. Campuses determine the amount of assistance required for transfers and record this on the nursing Admission Observation, the CareAssist profile, and the Resident Care Plan to provide communication to all staff regarding safe transfers. 3.1-38(a)(2)(B)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, record review, and interview, the facility failed to ensure non-pressure wounds were documented on the Treatment Administration Record, and wound treatments were performed in a timely manner as ordered by the physician for 1 of 6 residents observed for Quality of Care. (Resident 13) Findings include: The record for Resident 13 was reviewed on 1/16/25 at 1:53 p.m. The resident's diagnoses included, but were not limited to, Parkinson's disease, severe morbid obesity due to excess calories, type 2 diabetes mellitus with diabetic chronic kidney disease, SIRS (systemic inflammatory response syndrome) of non-infectious origin with acute organ dysfunction, muscle weakness, difficulty in walking, and unsteadiness on his feet. The Quarterly MDS (Minimum Data Set) assessment, dated 11/28/24, indicated the resident was cognitively alert and oriented. The nurse's note, dated 10/11/24 at 10:47 a.m.,	F 0684	F684 **1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident #13 was affected by the deficient practice. Immediate corrective action was to ensure wound care to the non-pressure wound was performed in a timely manner and documented on the Treatment Administration Record (TAR). Resident wound was assessed, and determined to have been healed. **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 with non-pressure wounds that require treatment administration have the potential to be affected. The Interim DHS conducted an audit of all like residents, without any other	02/09/2025

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	indicated that during the weekly skin assessment, the resident was observed to have an open, draining area to the left shin with redness around the area. The MD was made aware and new orders were received to culture any drainage and administer 100 mg (milligrams) of doxycycline BID (twice daily) for 10 days. The Wound Management note, dated 10/11/24 at 3:02 p.m., indicated the facility acquired diabetic ulcer to the left shin was observed. The wound measured 3.5 cm (centimeters) long by 1 cm wide with light seropurulent exudate. The nurse's note, dated 10/13/24 at 2:13 a.m., indicated the resident continued to receive the antibiotic for cellulitis. The resident indicated the wound was painful. The nurse was waiting for the wound culture results from the lab. The physician's order, dated 10/22/24, indicated to observe the open area to the left lower extremity dressing every shift for draining on the dressing and dislodgement twice daily. The October 2024 Treatment Administration Record (TAR), indicated on the resident's weekly skin assessments dated 10/4/24, 10/18/24, and 10/25/24 the resident had no skin impairments. On 10/11/24, the resident had one new skin impairment. The Wound Management note, dated 10/24/24 at 1:32 p.m., indicated the resident's diabetic ulcer measured 3.5 cm long by 2 cm wide with moderate serous exudate. The depth was partial thickness (loss of epidermis and into but not through the dermis). The wound was stable. The physician's order, dated 10/25/24, indicated to		deficiencies noted. All nursing staff who administer wound care to non-pressure wounds were in-serviced on procedures for following treatment orders, as well as completing documentation on the treatment administration record when complete. **3 What measures will be put into place, and what systemic changes will be made to ensure the deficient practice does not recur?** As a measure of ongoing compliance, DHS or designee will audit 3 residents with non-pressure wounds to ensure wound care is being completed per physician order and documented in the TAR when completed. Audits to be conducted 3x/week x 4 weeks, weekly x 4 weeks, every other week x 4 weeks, 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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	cleanse the wound to the left lower extremity with wound cleanser or normal saline, apply collagen silver to the wound and cover with a bordered SAD (suction assisted dressing) daily. The care plan, dated 11/1/24, indicated the resident had a diabetic ulcer to the left shin. The interventions, dated 11/1/24, included, but were not limited to, assess and record the condition of the skin surrounding the diabetic ulcer, observe and report signs of infection such as localized pain, redness, swelling, tenderness, drainage, odor, and fever, provide treatment per the MD order, notify the MD if the treatment was not effective, conduct the weekly skin assessments, measurement, and observe the diabetic ulcer and record. The Wound Management note, dated 11/14/24 at 5:31 a.m., indicated the diabetic ulcer measured 1 cm long by 0.5 cm wide with a partial thickness depth. There was no drainage. The CAR (Corrective Action Request)/Wound note, dated 11/14/24 at 12:14 p.m., indicated that the wound had improved, was healing appropriately, and the current treatment would continue. The nurse's note, dated 11/20/24 at 4:02 p.m., indicated the MD assessed the wound to the left shin. New orders were received for doxycycline for 10 days BID and to culture the wound. A culture was obtained. The CAR/Wound note, dated 11/21/24 at 12:15 p.m., indicated the area showed improvement, was healing appropriately, the current treatment was to be continued, and the wound care center representative was at the facility and observed the			

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	wound. The staff were advised to continue the current treatment. The nurse's note, dated 11/22/24 at 2:32 p.m., indicated the wound culture results were received and sent to the MD. No changes to the treatment orders were received. The nurse's note, dated 11/25/24 at 2:45 a.m., indicated the resident continued to receive doxycycline, related to the wound infection on the left shin. The treatment was completed as ordered at bedtime. Redness to the wound remained, with a raised area on the distal end of the wound. There was no active drainage observed. Staff would continue to monitor the wound for changes. The Wound Management note, dated 11/26/24 at 11:11 a.m., indicated the diabetic ulcer measured 1 cm long by 1 cm wide by 0.1 cm deep. There was a moderate amount of serosanguineous exudate, 95% granulation tissue and 5% slough. The wound was stable. The Wound Culture of the left lower extremity, dated 11/27/24, indicated Staphylococcus aureus (bacterium commonly found on the skin and in the nose). The November 2024 TAR indicated the resident's weekly skin assessments on 11/1/24, 11/8/24, 11/15/24, 11/22/24, and 11/29/24, indicated no skin impairments. The nurse's note, dated 12/9/24 at 3:39 a.m., indicated the treatment and monitoring were continued to the resident's left lower extremity wound. The skin remained to be red with dry flaky skin on the peri wound. The dressing was			

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	changed as ordered with yellowish drainage observed on the wound prior to cleaning. No increased warmth or swelling were present. The Wound Management note, dated 12/12/24 at 1:25 p.m., indicated the diabetic ulcer measured 0.8 cm long by 0.6 cm wide with full thickness depth (through dermis and down to the subcutaneous tissue or muscle). There was a moderate amount of serosanguineous exudate, 95% granulation tissue and 5% slough. The wound was stable. The CAR/Wound note, dated 12/18/24 at 3:40 p.m., indicated the current treatment of collagen silver to the wound bed and cover with SAD were continued. The area had improvement and was healing appropriately. The December 2024 TAR indicated the resident's weekly skin assessments on 12/6/24, 12/13/24, 12/20/24, and 12/27/24, indicated the resident had no skin impairments. The CAR/Wound note, dated 1/2/25 at 11:35 a.m., indicated the current treatment of collagen silver to the wound bed and cover with SAD were continued. The area had improvement and was healing appropriately. The current treatment would continue until healed. The Wound Management note, dated 1/2/25 at 3:20 p.m., indicated the diabetic ulcer measured 1 cm long by 1 cm wide. There was a light amount of serosanguineous exudate. The nurse's note, dated 1/10/25 at 8:13 p.m., indicated the resident was unstable on his feet and had a temperature of 102 degrees F (Fahrenheit). The resident was alert, had no confusion, and was oriented, but had been			

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	sleeping all day, and was not of his normal character. The resident's blood sugar was 175 mg/dL (milligrams per deciliter). He was shaky, diaphoretic, denied stomach pain, and was without appetite. Both lower extremities had warmth and redness, without odor or drainage present on the dressing. The MD was notified, and the resident was started on 100 mg of doxycycline BID for 10 days. Lab work of a CBC (complete blood cell count) and CHEM-8 (blood test to measure 8 different substances in the blood) were obtained. The MD was to be contacted immediately if the resident became hypotensive or tachycardic. The Wound Management note, dated 1/10/25 at 11:33 a.m., indicated the diabetic ulcer measured 0.3 cm long by 0.2 cm wide. There was full thickness depth, and the wound was improving. The nurse's note, dated 1/12/25 at 6:40 a.m., indicated the MD assessed the resident related to his condition and lab work. New orders were received for a Midline IV (intravenous) to be placed and to begin Clindamycin and Rocephin (ceftriaxone). The resident was to continue to receive the doxycycline. The physician's order, dated 1/12/25, indicated to administer 100 mg doxycycline hyclate twice daily for 10 days until 1/22/25. The physician's order, dated 1/12/25, indicated to administer 1 gram of ceftriaxone intravenously daily. The medication was unavailable on 1/12/25 and it was started on 1/13/25. The ceftriaxone was discontinued on 1/14/25. The nurse's note, dated 1/13/25 at 12:58 p.m., indicated the Midline dressing was soaked with			

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	blood. Flushing was performed and no resistance occurred. The dressing was changed and secured. One gram of IV Ceftriaxone was administered. The pharmacist contacted the nurse and indicated that 900 mg of Clindamycin was not available, but they had 600 mg and 300 mg. The MD was informed, and an order was received to administer 600 mg of Clindamycin IV every 8 hours for 3 days. The physician's order, dated 1/13/25, indicated to administer 600 mg clindamycin intravenously every 8 hours for 3 days. The resident received two doses. The nurse's note, dated 1/14/25 at 5:59 p.m., indicated the MD assessed the resident. New orders were received to discontinue the midline and IV medication and continue 100 mg of doxycycline twice daily. The nurse's note, dated 1/20/25 at 1:03 a.m., indicated the resident continued to have redness to the bilateral lower extremities. The resident reported occasional pain on the lower extremities. The dressing was changed on the left lower extremity wound. The January 2025 TAR indicated the resident's weekly skin assessments on 1/3/25, 1/10/25, and 1/17/25, indicated the resident had no skin impairments. The review of the January 2025 TAR on 1/21/25 at 9:38 a.m., indicated that the left lower extremity dressing changes had been performed during the night shift on 1/14/25, 1/15/25, 1/16/25, 1/17/25, 1/18/25, 1/19/25, and 1/20/25. During an observation on 1/16/25 at 8:46 a.m., Resident 13's last dressing change to the left shin,			

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	was dated 1/14/25 with no time, but illegible staff initials. The resident indicated that he thought the nurse did the dressing change every other day. The dressing corners were curled, and the dressing border appeared discolored. The skin just below the left shin dressing was dark pink in color at the width of the dressing. During an observation on 1/17/25 at 8:35 a.m., the resident's dressing dated 1/14/25 was still in place to the left shin. The corners of the dressing were curled, and the dressing border appeared discolored. The skin just below the left shin dressing was dark pink in color, at the width of the dressing. During an observation on 1/21/25 at 8:43 a.m., the resident's dressing to the left lower extremity shin was dated 1/19/25 with no time indicated. The resident was unsure of the last dressing change. The top left corner of the dressing was peeling up. Slight redness to a dark pink color to the skin was visible at the bottom of the dressing. During an observation and interview on 1/21/25 at 8:46 a.m., RN 3 indicated the MD would have seen the resident last Wednesday on 1/15/25, because he came to the facility on Wednesdays. The RN felt that the wound had improved and was smaller than it had been. The nurse indicated the dressing appeared to have been changed and when he saw the date on the dressing, he indicated that the dressing must not have been changed last evening. The wound was quarter sized with a yellow slough at the bottom half edge of the wound bed. There was a slight clear drainage present. Redness around the edges of the wound was present. During an interview on 1/21/25 at 2:20 p.m., RN 3			

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	indicated he would follow the physician's orders, obtain the measurements and assess the wounds. If he found that a dressing change had not been performed, he would follow up with the physician. The most current facility policy titled, Guidelines for Medication Orders, last revised 12/17/24 was provided on 1/21/25 by the Director of Nursing. The policy included, but was not limited to, " ... 1. Each resident shall be under the care of a licensed physician ... 2. A current list of orders will be maintained .... 9. Treatment orders ... a. When recording treatment orders specify ... 1. What is done, location and frequency and duration of treatment ..." 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on observation, interview and record review, the facility failed to ensure pressure ulcer dressing changes were completed per the physician order; a new pressure area was measured, tracked or treated; and interventions were in place related to floating a resident's heels for a resident at risk for pressure ulcers for 1 of 2 residents reviewed for pressure ulcers. (Resident 14) Findings include: The record for Resident 14 was reviewed on 1/15/25 at 11:00am. The resident's diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side; unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood	F 0686	F686 **1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident #14 was affected by the deficient practice. Immediate corrective action was to ensure wound care to the pressure wound was performed in a timely manner and documented on the TAR. Resident wound care was determined to have been in compliance with orders and interventions in place. **2 How other residents having the potential to be affected by the same deficient**	02/09/2025

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	disturbance, and anxiety; cognitive communication deficit; repeated falls; and unspecified severe protein-calorie malnutrition. The Quarterly Minimum Data Set (MDS) assessment, dated 10/27/2024, indicated the residents' cognition was severely impaired. The resident required staff assistance with Activities of Daily Living (ADL) The resident was out of the facility from 9/3/24 through 9/5/24, and was admitted to hospice services on 10/15/24. The care plan, revised on 6/18/24, indicated that the resident was at risk for skin breakdown related to impaired mobility, incontinence, edema, history of pressure wound, diagnosis. The interventions, included, but were not limited to: ted hose as ordered, on in morning and removed in the evening, dated 6/26/24; carrot to be placed in left hand at all times (revision on 1/12/24 the carrot was discontinued due to non-compliance), avoid shearing skin during positioning, turning, and transferring, conduct weekly skin assessment (pay particular attention to bony prominences), encourage and assist to turn and reposition for comfort and as needed, float heels as resident will allow, keep linens clean and dry, keep resident as clean and dry as possible, minimize skin exposure to moisture, pressure reducing cushion to chair, pressure reducing mattress to bed, use lifting device as needed for bed mobility (e.g. lift sheet, etc.), and use moisture barrier product to perineal area as needed. The care plan, dated 10/14/24, indicated that the resident required increased caloric intake, protein, and/or nutrient needs related to presence of impaired skin integrity. The interventions		**practice will be identified and what corrective action(s) will be taken?** All residents who have pressure wounds that require treatment administration have the potential to be affected. The interim DHS conducted an audit of all like residents, without any other deficiencies noted. All nursing staff who administer wound care for pressure wounds were in-serviced on procedures for following treatment orders, as well as completing documentation on the treatment administration record when complete. **3 What measures will be put into place, and what systemic changes will be made to ensure the deficient practice does not recur?** As a measure of ongoing compliance, DHS or designee will audit all residents with pressure wounds to ensure wound care is being completed per physician order, documented in the TAR when completed. Audits to be conducted daily 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	

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	included, but were not limited to, the dietitian was to re-evaluate as indicated, encourage fluids, labs as ordered by the physician, obtain weight as ordered or as needed, provide diet as ordered, and provide supplements, vitamins, and/or minerals as ordered. The care plan, dated 11/1/24, indicated Resident 14 had a Kennedy Terminal Ulcers/Skin Failure: to the left thigh, right hip, left ankle, and Coccyx. The left thigh pressure ulcer was healed on 11/7/24. The interventions included, but were not limited to, treatment as ordered, notify the physician as needed, provide preventative measures as recommended, observe and treat pain per physician's orders, hospice referral as appropriate, and collaborate with physician and hospice provider as appropriate in managing pain. The physician's order, dated 7/31/23, indicated to encourage the resident to float her heels while in bed twice a day; encourage the resident to turn and reposition while in bed twice a day. The physician's order, dated 9/2/24, indicated staff were to observe the coccyx dressing to the resident's open area(s) every shift for drainage on dressing and dislodgement twice daily. The physician's order, dated 9/6/24, indicated to cleanse the resident's coccyx wound with cleanser or normal saline apply skin prep, apply calcium alginate to wound bed, apply Flagyl to wound bed, pack with normal saline soaked gauze, and cover with foam (gentle or life) dressing twice a day. The physician's order, dated 9/17/24, indicated staff were to clean the resident's area to the left lower buttocks with wound cleaner. Apply Medihoney to the area, and cover with a foam		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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	gauze daily. The physician's order, dated 10/2/2024, indicated the staff were to observe the resident's left ankle, dressing to open area(s) every shift for drainage on dressing and dislodgement. The physician's order, dated 10/2/2024, indicated staff were to observe the resident's hip on the right side every shift. Staff may peel back and view the area to monitor if the area has opened twice a day. The Wound Evaluation form, dated 10/3/24, indicated the resident's coccyx wound was first observed on that 10/3/24, and it was not present on admission. The resident's wound measurements dated 10/3/2024 at 3:24 p.m., were as followed: - Coccyx wound was 3.3 cm long X (by) 4.5 cm wide - Left ankle wound was 4.1 cm long X 3.2 cm wide - Right hip wound was 0.1 cm long X 0.1 cm wide A nurse's note, dated 10/11/24, indicated that the resident had an area to coccyx with yellow slough to the wound bed. The peri-wound was intact. The wound dressing was reapplied. The physician was made aware of the wound to the coccyx. A nurse's note, dated 10/11/2024, indicated that the resident had open areas to both gluteal folds. The open areas were measured 0.5cm x0.5cm. The physician's order, dated 10/21/24, indicated cleanse wound with cleanser or normal saline, apply skin prep, apply calcium alginate to wound bed, apply Flagyl to wound bed, pack with normal saline soaked gauze, and cover with foam (gentle			

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	or life) dressing PRN. The resident's wound dressings were to be changed as needed or when the dressing became dislodge or soiled. The Wound Evaluation form, dated 10/25/24 at 1:46pm, indicated the resident's wound measurements dated 10/25/24 were as followed: - Coccyx wound was 3.4 cm long X 2.9 m wide - Left ankle wound was 2.3 cm long X 3.2 cm wide - Right hip wound was 0.8 cm long X 1.1 cm wide A wound culture collected of the coccyx on 11/8/2024 6:15 PM showed mixed anaerobic organisms, none predominating. The physician's order, dated 12/21/24, indicated staff were to clean the resident's left lower buttock area with wound cleaner, apply Medi-honey to area, cover with foam gauze, and change the dressing for soilage or dislodgement. The Wound Evaluation form, dated 1/7/25 at 1:46pm, indicated the resident's wound measurements dated 1/7/25 were as followed: - Coccyx wound was 3.3 cm long X 4.4 cm wide, - Left ankle wound was 4.1 cm long X 3.3 cm wide, - Right hip wound was 0.2 cm long X 0.1 cm wide, - Left Buttock wound was 1.7 cm long X 1.7 cm wide. The Wound Evaluation form, dated 1/14/25 between 10:37 am and 10:45 am, indicated the resident's wound measurements dated 1/14/25 were as followed: - Coccyx wound was 6.5 cm long X 5 cm wide, - Left ankle wound was 4.25 cm long X 3.75 cm wide,			

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	- Right hip wound was 1.25 cm long X 1 cm wide, - Left buttock wound was 2 cm long X 2.5 cm wide. - left outer buttock red/non blanchable, and a new small open area was observed to the top of coccyx. There were no wound notes to indicate a fifth area (left outer buttock/top of coccyx) had been measured, tracked or treated. During observation on 1/15/25 at 09:20 am The resident was in bed with her eyes opened, concave mattress in place, the resident's bilateral heels were not floated and lying directly on the resident's bed. During observation on 1/16/25 11:00 am, the resident was resting in bed on her left side with her eyes closed. The resident's bilateral heels were not floated and lying directly on the resident's bed. The physician's order, dated 1/16/25, indicated the resident was to have a weekly skin assessment completed. The nurse must complete the skin observation tool and document any new areas on the form and complete a change in condition every Thursday. During an observation of Resident 14's wound care on 1/17/25 10:09 a.m., Licensed Practical Nurse (LPN) 4 completed hand hygiene, put on two pairs of gloves on, and pulled the resident's curtain for privacy. The resident was lying in her concave mattress with pillows propped under both sides of the buttocks and a pillow was in-between the resident's legs. The resident's pants were taken off and the nursing staff rolled the resident to the right side. Certified Nurse aide			

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	(CNA) 5 was assisting the nurse. The resident's coccyx dressing dated 1/15/25 was removed and the dressing had a moderate amount of green drainage. The peri-wound was reddened, the wound bed contained slough, and the nurse reported that the wound tunneled. There was a small open area observed to the top of the resident's coccyx. There was no treatment ordered at the time of the dressing change. The resident's dressing for the left buttock was dated 1/15/25 and was removed by the nurse. The left buttock wound had a small amount of eschar and the peri-wound was reddened. The resident's dressing for the left ankle was dated 1/15/25 and was removed by the nurse. The old dressing was soaked through with yellow drainage and slough was noted in the wound bed. A Clinical at-Risk (CAR) /Wound Interdisciplinary Team's (IT) progress note dated, 01/17/25 at 1:16 p.m. indicated the resident had no wounds on admission. During a confidential staff interview from 1/15/24 to 1/22/24, the staff member indicated the resident's wounds had gotten bad at one point. The staff member did not believe the residents pressure wounds were Kennedy ulcers and indicated most pressure wounds could be prevented if the staff would turn and reposition the residents every two hours. During an interview on 01/17/25 09:15 a.m., LPN 4 indicated the resident's wounds were to have the dressings changed daily. Hospice would come in once to twice a week to do the dressing changes. All of the resident's wounds came at once. During an interview with the Executive Director (ED), Director of Nursing (DON), and Clinical			

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	Support 6 on 1/21/25 11:00 a.m., the Clinical Support Nurse 6 indicated that the resident's wounds could not be classified as Kennedy ulcers due to the length of the time the pressure ulcers have been treated. The DON indicated that the wound to the coccyx was not a historic chronic wound. When asked about prevention interventions, treatment and the amount of skin wounds, the DON and clinical support indicated "We really haven't figured that out." The DON indicated that the resident was on an air mattress and now had a BRODA chair. The family did not want the resident to take a multi-vitamin or any protein supplements. The ED reported that the resident was on hospice as of 10/15/2024 and had a decline in health since October. The most current facility policy titled, Guidelines for General Wound and Skin care policy, last revised 2/23/23 was provided on 1/21/25 by the Director of Nursing. The policy included, but was not limited to, ",..The purpose of this policy is to provide measures that will promote and maintain good skin integrity ...The policy included, but was not limited to, ...2. Turn/reposition residents who are immobile ...4 Use pillows or wedges for positioning ...14. Perform the wound treatment ...18. Date, time and initial all dressings ...20. Document type of wound ...". 3.1-40(a)(1) 3.1-40(a)(2)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey Dates: January 15, 16, 17, 21, and 22, 2025	R 0000	This submission of the plan of correction does not indicate an admission by River Terrace Health Campus that the findings and	

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	Facility number: 013535 Residential Census: 29 River Terrace Heath Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed on January 28, 2025.		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 January 22.2025. 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	