STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155849	A. BUILDING ______ B. WING ______	C 12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000	INITIAL COMMENTS This visit was for the Investigation of Nursing Home Complaint IN00447558. This visit included Residential Complaint IN00447407. Complaint IN00447558 - Federal/State deficiency related to the allegations is cited a F755. Complaint IN00447407 - No deficiencies related to the allegation is cited. Survey date: December 9 and 10, 2024 Facility number: 013535 Provider number: 155849 AIM number: 300018660 Census Bed Type: SNF/NF: 36 Residential: 29 Total: 65 Census Payor Type: Medicare: 15 Medicaid: 15 Other: 6 Total: 36 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 17, 2024.	F 000		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 755		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155849	A. BUILDING ______ B. WING ______	C 12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 755	Continued From page 1 them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident (Resident B) received Lantus (long-acting diabetic medication) as ordered by the physician for 1 of 3 residents reviewed for pharmacy services. Findings include: The clinical record for Resident B was reviewed	F 755	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155849	A. BUILDING ______ B. WING ______	C 12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 755	Continued From page 2 on 12/9/24 at 8:05 p.m. The resident's diagnosis included, but was not limited to, diabetes. The Care Plan, dated 11/18/24, indicated the resident was at risk for hypoglycemia/hyperglycemia due to diabetes mellitus and staff were to administer the resident's medications as ordered. The Admission Order, dated 11/14/24, indicated the resident was to receive Lantus insulin, 20 units subcutaneous at bedtime. The EDK (emergency drug kit) record indicated, on 11/14/24 at 9:33 p.m., a Lantus Solostar insulin pen was removed for Resident B. The November 2024 Medication Administration Record indicated the resident received 20 units of the Lantus insulin at bedtime on 11/14/24. The progress note, dated 11/16/24 at 11:57 a.m., indicated the resident was sweating and her blood sugar was 504. The physician was notified with a new, one time, order for 8 units of Novolog (short acting insulin) insulin and 20 units of Lantus insulin. The resident was also to resume the normal timing of her Lantus at bedtime. The resident's Medication Administration Record lacked documentation of the administration of the Lantus insulin on 11/15/24. The record was documented that the resident did not receive the insulin due to the medication being unavailable. During an interview on 12/10/24 at 12:01 p.m., RN (Registered Nurse) 6 indicated she admitted the resident on 11/14/24. She pulled the Lantus from the EDK to administer, which had several	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155849	A. BUILDING ______ B. WING ______	C 12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 755	Continued From page 3	F 755		

doses in it. She placed the insulin pen in a bag, put the resident's name on it and then placed pen in the top left drawer.

During an interview on 12/10/24 at 12:22 p.m., the ADON (Assistant Director of Nursing) indicated she had gone to the EDK and the Lantus was not available. She called pharmacy to have it sent stat and it was delivered after she left on 11/16/24. She did not notify the physician as he usually had a standing order that if a resident was not symptomatic then the medication can be administered when it arrived from pharmacy. She checked the medication cart and could not find any Lantus. She had been in and out of the resident's room several times and the resident was not symptomatic. The family was in the room all night and never asked about it.

During an interview on 12/10/24 at 1:03 p.m., the DON (Director of Nursing) indicated the resident had moved rooms. The residents' medications were moved to the other cart but staff did not move the insulin. The resident did have insulin available for administration on 11/15/24.

On 12/10/24 at 2:00 p.m., a current copy of the document titled "Medication Administration - General Guidelines" dated 11/18 was provided. It included, but was not limited to, "Policy...Medications are administered as prescribed in accordance with good nursing principles and practices...Procedure...If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room and facility (e.g., other units) are searched...."

The Past noncompliance began on 11/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155849	A. BUILDING ______ B. WING ______	C 12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 755	Continued From page 4 between 7:00 p.m. and 11:30 p.m. The deficient practice was corrected by 11/18/24 after the facility implemented a systemic plan that included the following actions: All nurses were educated on room moves which included room moves that involved changing medication carts (11/18/24); Ongoing audits were implemented to ensure all medications are moved when residents moved rooms (11/18/24). This Citation relates to Complaint IN00447558 3.1-25(g)(2)	F 755		