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	12/04/2023

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 a Recertification and State Licensure Survey. This visit included a State Residential Licensure survey. Survey Dates: November 27, 28, 29, 30, December 1 and 4, 2023. Facility Number: 013535 Provider Number: 155849 AIM number: 300018660 Census Bed type: SNF/NF: 36 Residential Census: 23 Total: 59 Census payor type: Medicare:13 Medicaid: 20 Other: 3 Total: 36 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on December 10, 2023.	F 0000	Submission of this 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 quality of 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 hereby 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 December 4, 2023. We initiated immediate interventions when concerns were identified on this date. We respectfully request a paper 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 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rhonda Gibson	Executive Director	12/19/2023

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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	medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on record review and interview, the facility failed to assess and re-evaluate 2 of 2 residents for self-administration of respiratory treatments or medications (inhalers). (Residents 10 and 14) Findings include: 1. The record for Resident 10 was reviewed on 12/1/23 at 9:37 a.m. The diagnoses included, but were not limited to, influenza due to identified novel influenza A virus with other manifestations; acute respiratory failure, unspecified whether with hypoxia or hypercapnia; chronic obstructive pulmonary disease, unspecified; and pulmonary fibrosis, unspecified. The Quarterly Minimum Data Set (MDS) assessment, dated 12/27/22, indicated the resident was cognitively intact and had no impairment in functional range of motion of upper extremities. The December 2023 monthly physician's order, indicated the resident had an order, dated 12/22/22, for albuterol sulfate solution for nebulization, 1 vial inhalation for SOA (shortness of air) every 6 hours PRN (as needed). The Medication Administration Record (MAR), dated between September and November 2023, indicated the following days the resident self-administered his breathing treatment: - September : 9/13, 9/18, 9/25, 9/27, and 9/29. -October: 10/2, 10/8, 10/9, 10/13, 10/16, 10/17, 10/19, 10/23, 10/30 and 10/31.	F 0554	**1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Immediate corrective action consisted of residents #10 and #14 having been assessed to ensure ability to self- administer breathing treatments, then presented to the physician for evaluation, and an order for self-administration was obtained, and care plan updated. **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 receiving breathing treatments have the potential to be affected. The Director of Health Services (DHS) conducted an audit of all like resident, without any other deficiencies noted. All nursing staff who administer breathing treatments were in-serviced on self-administration of medication. **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	12/22/2023

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	- November: 11/8, 11/10, 11/14, 11/17, 11/21, 11/24, and 11/28. Documentation was lacking of an initial assessment of the resident's ability and a physician's order for self administration of the breathing treatment. During an interview with the Director of Health Services (DHS) on 12/1/23 at 1:55 p.m., she indicated the resident did not have a Self Administration of Medication assessment. 2. The record for Resident 14 was reviewed on 11/30/23 at 12:58 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) with (acute) exacerbation; acute and chronic respiratory failure with hypoxia; fluid overload, unspecified; hypertensive heart disease with heart failure; and unspecified atrial fibrillation. The Quarterly MDS assessment, dated 9/19/23, indicated the resident was cognitively intact and had no impairments in upper body functional range of motion. The December 2023 monthly physician's order indicated the resident had the following orders, dated 7/25/23 : - arformoterol solution for nebulization, 1 vial for inhalation twice daily for COPD. - ipratropium-albuterol solution for nebulization, 1 vial for inhalation every 6 hours for COPD. The MARs, dated July through November 2023, indicated the following days the resident self-administered his arformoterol solution		audit all new admissions and readmissions who have orders for breathing treatments to ensure applicable self-administration compliance, as well as quarterly updates on existing residents in daily Clinical Care Meeting (CCM) 5x/week x 4 weeks, 3x/week x 3 months, and 1x/week x 2 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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	breathing treatment: - July: 7/26, 7/27, 7/30, and 7/31. - August: 8/1, 8/2, 8/4, 8/5, 8/6, 8/7, 8/8, 8/9 twice, 8/10. 8/11, 8/12, 8/13, 8/14, 8/15, 8/16, 8/17, 8/18, 8/20, 8/21, 8/22 twice, 8/23, 8/24, 8/26, 8/27, 8/28, 8/29, and 8/30. - September: 9/1, 9/2, 9/4, 9/6, 9/7, 9/8, 9/9, 9/10, 9/11, 9/12, 9/13, 9/15, 9/16, 9/18, 9/19, 9/20, 9/21, 9/22, 9/23, 9/24, 9/25, 9/26, 9/27, 9/28. 9/29, and 9/30. - October: 10/1, 10/2, 10/3, 10/5, 10/6, 10/7, 10/8, 10/9, 10/10, 10/11, 10/13, 10/14, 10/16 twice, 10/17, 10/19, 10/20, 10/21, 10/22, 10/23, 10/27, 10/28, 10/29 and 10/30. - November: 11/2, 11/3 times 2, 11/4, 11/5, 11/6, 11/7,11/8 twice, 11/10, 11/11, 11/13, 11/14, 11/16, 11/17, 11/18, 11/19, 11/21, 11/22, 11/24, 11/25, 11/26, 11/27, 11/28, and 11/30. The MARs, dated July through November 2023, indicated the following days the resident self-administered his ipratropium-albuterol solution for nebulization: - July: 7/27, 7/28 times 2, 7/29, 7/30, and 7/31. - August: 8/1 twice, 8/2, 8/3 twice, 8/4, 8/5 twice, 8/6 times 2, 8/7 three times, 8/8 thee times, 8/9 twice, 8/10, 8/11 twice, 8/12 twice, 8/13, 8/14, 8/15, 8/16, 8/17 twice, 8/19, 8/20 twice 2, 8/21 four times, 8/22 twice, 8/23 three times, 8/24 twice, 8/25 twice, 8/27, 8/28 twice, 8/29 twice, 8/30, and 8/31 twice. - September: 9/2, 9/3 twice, 9/4 three times, 9/5 three times, 9/6, 9/7 twice, 9/8 twice, 9/9, 9/10 three			

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	times, 9/11 twice, 9/12, 9/13, 9/14 times 2, 9/16 twice, 9/17, 9/19 twice, 9/20 twice, 9/22, 9/23, 9/24, 9/25, 9/26 three times, 9/27 twice, 9/28, 9/29, and 9/30 twice. - October: 10/1 twice, 10/2 twice, 10/3 twice, 10/4 twice, 10/6 twice, 10/7, 10/8, 10/9, 10/10, 10/11, 10/12 twice, 10/13, 10/14, 10/15 twice, 10/16 four times, 10/17, 10/18, 10/19, 10/20, 10/21 three times, 10/22, 10/23, 10/24 twice, 10/27, 10/28, 10/29 twice, 10/30 twice, and 10/31. - November: 11/1, 11/3 twice, 11/4 twice, 11/5 twice, 11/7, 11/8, 11/10, 11/11, 11/12 twice, 11/13 twice, 11/14, 11/15, 11/17, 11/18, 11/20 twice, 11/21 twice, 11/23 twice, 11/24 four times, 11/25, 11/26 twice, 11/27 twice, and 11/28 twice. A Self-Administration of Medication assessment, dated 9/21/21, was completed for the resident to self-administer his breathing treatments. Documentation was lacking of the assessments having been re-evaluated quarterly and PRN when changes occurred (i.e. hospitalizations). A physician's order was also lacking. During an interview with RN 4 on 12/1/23 at 2:00 p.m., she indicated she had let the residents administer their own breathing treatments and inhalers. A physician's order was needed in order to do so and she thought the residents had one. During an interview with RN 3 on 12/1/23 at 2:05 p.m., she indicated she had let the residents administer their own breathing treatments and inhalers. A physician's order was needed in order to do so. During an interview on 12/1/23 at 3:30 p.m., the			

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	DHS indicated she did not realize the nurses were letting the residents do their own respiratory treatments. The facility's current Guidelines for Self-Administration of Medications, included, but was not limited to, "Purpose- To ensure the safe administration of medication for residents who request to self-medicate or when self-medication is part of their plan of care. Procedures: 1. Residents requesting to self-medicate or has self-medication as part of their plan of care shall be assessed using the observation [name of company]- Self-Administration of medication within the electronic health record (EHR). Results of the assessment will be presented to the physician for evaluation and an order for self-medication. a. That order should include the type of medication(s) the resident is able to self-medicate, Oral meds, oral meds with the exception of..., nebulizer treatment only, all medications including...inhalers...5. Periodic verification of administration compliance will be observed by nursing staff...7. The Assessment will be reviewed quarterly, and PRN with change of condition. The assessment will be documented in the EHR." 3.1-11(a)			
F 0623 SS=E Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The			

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	facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge;			

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	(ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility			

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	closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on record review and interview, the facility failed to ensure 2 of 5 residents or responsible parties were provided written notice of Transfer/Discharge upon transfer to an acute care facility. (Residents 10 and 14) Findings include: 1. The record for Resident 10 was reviewed on 12/1/23 at 9:37 a.m. The diagnoses included, but were not limited to, influenza due to identified novel influenza A virus with other manifestations; acute respiratory failure, unspecified whether with hypoxia or hypercapnia; chronic obstructive pulmonary disease, unspecified; and pulmonary fibrosis, unspecified. The Quarterly Minimum Data Set (MDS) assessment, dated 12/27/22, indicated the resident was cognitively intact A nurse's note, dated 12/13/23 at 10:36 p.m., indicated the resident was short of air with oxygen levels between 78 and 84% (percent) on room air and between 88 and 90% on 2 liters of oxygen. The physician was made aware and gave a new order for the resident to be transferred to the hospital. The resident's daughter was made aware and was agreeable.	F 0623	**1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** No adverse effects occurred to residents #10 and #14 due to alleged deficient practices. **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 transfer or discharge have the potential to be affected by the alleged deficient practice. All nursing staff who transfer patients were in-serviced on the transfer policy by DHS. **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 transferred or discharged residents in CCM for proper	12/22/2023

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	A nurse's note, dated 12/19/23 at 2:40 a.m., indicated the resident returned from dialysis extremely weak, shaking uncontrollably and unable to talk. The physician was notified and a new order was received to transfer the resident to the hospital. A transfer packet was sent with the resident to the hospital. Documentation was lacking that the resident or the responsible party were given written notice at either transfers to the hospital of the reasoning for the resident to be transferred to the hospital or which hospital. 2. The clinical record for Resident 14 was reviewed on 11/30/23 at 12:58 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) with (acute) exacerbation; acute and chronic respiratory failure with hypoxia; fluid overload, unspecified; hypertensive heart disease with heart failure; and unspecified atrial fibrillation. The Quarterly MDS assessment, dated 9/19/23, indicated the resident was cognitively intact. A nurse's note, dated 2/26/23 at 4:56 p.m., indicated the resident complained of not being able to breathe and not feeling well. The resident was also pale and indicated he felt too weak to stand to go to the bathroom. The physician was notified and new orders were received to send the resident to the emergency room. The family was notified. A nurse's note, dated 4/24/23 at 9:54 a.m., indicated that when the nurse entered the resident's room, he was observed to be holding his right side of chest and side and indicated he		notification of transfer or discharge to resident or responsible party 5x/week x 4 weeks, 3/weeks x 3 months, and 1x/week x 2 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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	couldn't move his legs. The resident continued to complain of chest pain which was unrelieved with medication. EMS (Emergency Medical Services) was called and transported the resident to the hospital. His family member was called and indicated would meet him at the hospital. A nurse's note, dated 5/8/23 at 5:02 a.m., indicated the resident complained of pain at 2:00 a.m. PRN (as needed) pill given but the resident continued to complain of worsening pain and was losing the ability to use his legs and had nausea. The resident was asked several time if he wished to go to the hospital for evaluation but the resident declined as he thought they couldn't do anything for him. The note indicated staff would continue to monitor. A nurse's note, dated 7/19/23 at 11:33 a.m., indicated the resident's physician was in to see him and spoke with him about Hospice. After listening to the resident, new orders were given to transfer the resident to the hospital for respiratory difficulties and edema. Documentation was lacking that the resident or the Responsible party were given written notice at either transfers to the hospital of the reasoning for the resident to be transferred to the hospital or which hospital. During an interview with RN 3 on 12/1/23 at 10:45 a.m., she indicated that when she sent a resident out to the hospital, she completed the Transfer/Discharge form and put it into the packet to hand to the EMS workers when the resident was transferred. She indicated she did not give the form to the resident nor to their responsible party at time of transfer.			

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	During an interview with RN 4 on 12/1/23 at 10:55 a.m., she indicated she completed the Transfer/Discharge form, made a copy and attached it to the residents' paperwork being sent with them. She indicated she did not give it to the resident nor the responsible party. During an interview with the Social Worker on 12/1/23 at 11:30 a.m., she indicated she was not responsible for talking to or completing the Transfer/Discharge form to give to the resident or responsible party. During an interview with the Director of Health Services (DHS) on 12/1/23 at 11:35 a.m., she indicated nursing went over the Transfer/Discharge form with the resident or Responsible party as to why the resident was going to the hospital and which one if they were able to understand and there was time to do so and had them sign it. She further indicated that if residents did not have family to come in much, the nurses did not always make attempts to call or mail the forms to them. During an interview with the resident on 12/1/23 at 12 p.m., the resident did not remember anyone going over the Transfer/Discharge form with him or asked him to sign something. 3.1-12(a)(6)(A)			
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic			

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	155849	A. BUILDING 00 B. WING	12/04/2023

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	leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on record review and interview, the facility failed to ensure 3 of 5 residents or responsible parties were provided written notice of and signed the facility's bed hold policy upon transfer to an acute care facility. (Residents 10,14 and 31) Findings include: 1. The record for Resident 10 was reviewed on 12/1/23 at 9:37 a.m. The diagnoses included, but were not limited to, influenza due to identified novel influenza A virus with other manifestations; acute respiratory failure, unspecified whether with hypoxia or hypercapnia; chronic obstructive pulmonary disease, unspecified; and pulmonary fibrosis, unspecified.	F 0625	**1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** No adverse effects occurred to residents #10 and #14 due to alleged deficient practices. **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 discharge have the potential to be affected by the	12/22/2023

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	The Quarterly Minimum Data Set (MDS) assessment, dated 12/27/22, indicated the resident was cognitively intact A nurse's note, dated 12/13/23 at 10:36 p.m., indicated the resident was short of air with oxygen levels between 78 and 84% (percent) on room air and between 88 and 90% on 2 liters of oxygen. The physician was made aware and gave a new order for the resident to be transferred to the hospital. The resident's daughter was made aware and was agreeable. A nurse's note, dated 12/19/23 at 2:40 a.m., indicated the resident returned from dialysis extremely weak, shaking uncontrollably and unable to talk. The physician was notified and a new order was received to transfer the resident to the hospital. A transfer packet was sent with the resident to the hospital. Documentation was lacking that the resident or the Responsible party were given or had the facility's bed hold policy explained to them and had them sign a copy of it for either transfers. 2. The clinical record for Resident 14 was reviewed on 11/30/23 at 12:58 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) with (acute) exacerbation; acute and chronic respiratory failure with hypoxia; fluid overload, unspecified; hypertensive heart disease with heart failure; and unspecified atrial fibrillation. The Quarterly MDS assessment, dated 9/19/23, indicated the resident was cognitively intact. A nurse's note, dated 2/26/23 at 4:56 p.m.,		alleged deficient practice. All nursing staff who discharge residents, and business office manager were in-serviced on the bed hold policy by DHS. 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 transferred or discharged residents in CCM for proper notification of bed hold policy to resident or responsible party 5x/week x 4 weeks, 3/weeks x 3 months, and 1x/week x 2 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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	indicated the resident complained of not being able to breathe and not feeling well. The resident was also pale and indicated he felt too weak to stand to go to the bathroom. The physician was notified and new orders were received to send the resident to the emergency room. The family was notified. A nurse's note, dated 4/24/23 at 9:54 a.m., indicated that when the nurse entered the resident's room, he was observed to be holding his right side of chest and side and indicated he couldn't move his legs. The resident continued to complain of chest pain which was unrelieved with medication. EMS (Emergency Medical Services) was called and transported the resident to the hospital. His family member was called and indicated would meet him at the hospital. A nurse's note, dated 5/8/23 at 5:02 a.m., indicated the resident complained of pain at 2:00 a.m. PRN (as needed) pill given but the resident continued to complain of worsening pain and was losing the ability to use his legs and had nausea. The resident was asked several time if he wished to go to the hospital for evaluation but the resident declined as he thought they couldn't do anything for him. The not indicated staff would continue to monitor. A nurse's note, dated 7/19/23 at 11:33 a.m., indicated the resident's physician was in to see him and spoke with him about Hospice. After listening to the resident, new orders were given to transfer the resident to the hospital for respiratory difficulties and edema. Documentation was lacking that the resident or the Responsible party were given or had the facility's bed hold policy explained to them and			

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	had them sign a copy of it for any of the transfers. During an interview with RN 3 on 12/1/23 at 10:45 a.m., she indicated that when she sent a resident out to the hospital, she completed the Transfer/Discharge form with the bed hold policy and put it into the packet to hand to the EMS workers when the resident was transferred. She did not explain or give the form to the resident or to their Responsible party to sign at time of transfer to the hospital. During an interview with RN 4 on 12/1/23 at 10:55 a.m., she indicated she completed the Transfer/Discharge form, including the facility bed hold policy, made a copy and attached it to the residents' paperwork being sent with them. She did not explain or give it to the resident or the responsible party. 3. The record for Resident 31 was reviewed on 11/29/23 at 9:19 a.m. The diagnoses included, but were not limited to, displaced fracture of surgical neck of the left humerus, multiple fractures of the pelvis, type II diabetes, hypo-osmolality and hyponatremia, and disorders of bone density and structure. The nurse's note, dated 11/8/23 at 7:00 p.m., indicated the physician's office was called and notified the of pre surgery labs which indicated the resident's had a sodium of 118. The Medical Director was notified, and a new order was received to send her to the emergency room (ER) due to a seizure risk. The resident's family member was notified and stated he would take the resident to ER and would be here in 10 minutes. Report was called to the hospital ER. The transfer paperwork was sent with the resident. The nurse's note, dated 11/9/23 at 2:17 a.m.,			

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	indicated the hospital was called for a status on the resident and informed she was being admitted for a critical sodium. Review of the Resident Transfer Form dated 11/8/23, lacked documentation indicating the form was signed and dated by the resident or the resident's family member. During an interview with the Social Worker on 12/1/23 at 11:30 a.m., she indicated she was not responsible for talking to or completing the Transfer/Discharge form and bed hold policy to give to the resident or Responsible party. During an interview with the Director of Health Services (DHS) on 12/1/23 at 11:35 a.m., she indicated nursing went over the bed hold policy with the resident if they were able to understand and there was time to do so. They would have the resident sign the bed hold policy and then scanned it into their charts. If there was not time or the resident was not capable of understanding, then nursing would call or told the family (if present) that the facility would hold the bed for their return. Nursing documented this conversation by writing "Family notified". She indicated the note did not specifically indicate that the family was actually told about the bed hold policy. If residents did not have family that came in, nursing did not always make several attempts to call or mail the forms to the responsible party to sign. The facility's current Bed Hold policy, dated effective 9/24/18, included, but was not limited to, "Short Definition: Residents and responsible parties have the right to be informed of the campus bed hold policy and state plan regarding bed hold."			

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	3.1-12(a)(25) 3.1-12(a)(26)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility failed to develop a Self-Administration of Medication plan of care for 2 of 2 residents who were self-administering respiratory treatments and inhalers. (Residents 10 and 14).	F 0657	1 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?**	12/22/2023

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	Findings include: 1. The record for Resident 10 was reviewed on 12/1/23 at 9:37 a.m. The diagnoses included, but were not limited to, influenza due to identified novel influenza A virus with other manifestations; acute respiratory failure, unspecified whether with hypoxia or hypercapnia; chronic obstructive pulmonary disease, unspecified; and pulmonary fibrosis, unspecified. The Quarterly Minimum Data Set (MDS) assessment, dated 12/27/22, indicated the resident was cognitively intact and had no impairment in functional range of motion of upper extremities. The December 2023 monthly physician;s order indicated the resident had an order, dated 12/22/22, for albuterol sulfate solution for nebulization, 1 vial inhalation for SOA (shortness of air) every 6 hours PRN (as needed). The MARs indicated that during the months of September to November 2023, the resident had multiple self-administrations of his respiratory medication. Documentation was lacking of plan of care to address Self-Administration of Medication. 2. The clinical record for Resident 14 was reviewed on 11/30/23 at 12:58 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) with (acute) exacerbation; acute and chronic respiratory failure with hypoxia; fluid overload, unspecified; hypertensive heart disease with heart failure; and unspecified atrial fibrillation.		Immediate corrective action was that residents #10 and #14 were appropriately assessed to ensure ability to self-administer breathing treatments, then presented to the physician for evaluation and an order for self-administration of medication was obtained, and a care plan was then created for each resident. **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 breathing treatments have the potential to be affected. Minimum Data Set Coordinator conducted an audit of all residents who self-administer breathing treatments to ensure care plan is in place and/or updated. 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 new admissions or readmissions who receive breathing treatments for appropriate care plan, as well as all ongoing residents to ensure update of care plan appropriately in CCM 5x/week x 4 weeks, 3/week x 3 months, and 1x/week x 2 months.	

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	The Quarterly MDS assessment, dated 9/19/23, indicated the resident was cognitively intact and had no impairments in upper body functional range of motion. The December 2023 monthly physician's order indicated the resident had the following orders, dated 7/25/23: - arformoterol solution for nebulization, 1 vial for inhalation twice daily for COPD. - ipratropium-albuterol solution for nebulization, 1 vial for inhalation every 6 hours for COPD. The MARs indicated that during the months of July to November 2023, the resident had multiple self-administrations of his respiratory medications. Documentation was lacking of plan of care to address Self-Administration of Medication. During an interview with RN 4 on 12/1/23 at 2:00 p.m., she indicated she had let the residents administer their own breathing treatments and inhalers. During an interview with RN 3 on 12/1/23 at 2:05 p.m., she indicated she had let the residents administer their own breathing treatments and inhalers. During the final exit meeting with the facility on 12/1/23 at 3:30 p.m., the Director of Health Services (DHS) indicated she did not realize the nurses were letting the residents do their own respiratory treatments. The facility's current Guidelines for		**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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	Self-Administration of Medications, included, but was not limited to, "Purpose- To ensure the safe administration of medication for residents who request to self-medicate or when self-medication is part of their plan of care. Procedures: 1. Residents requesting to self-medicate or has self-medication as part of their plan of care shall be assessed using the observation Trilogy-Self-Administration of medication within the electronic health record (EHR)...6. A Self-Administration plan of care will be initiated and updated as indicated..." Cross Reference F554 3.1- 35(a) 3.1-35(b)(1) 3.1-35(d))(1) 3.1-35(d)(2)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on interview and record review, the facility failed to ensure showers were provided for dependent residents for 2 of 5 residents reviewed for Activities of Daily Living. (Residents 8 and 22) Findings included: 1. The clinical record for Resident 8 was reviewed on 12/1/23 at 11:00 a.m. The diagnoses included, but were not limited to, lack of coordination, abnormalities of gait and mobility, unsteadiness on his feet, generalized weakness, and hemiplegia affecting the right dominant side.	F 0677	1 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Immediate corrective action was that residents #8 or #22 were immediately offered a shower or bath of their preference. Resident #22 care plan was updated to reflect preference of 3x/week shower and/or bath. **2 How other residents having**	12/22/2023

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	The Quarterly MDS (Minimum Data Set) assessment, dated 11/5/23, indicated the resident was cognitively intact. He required maximal assistance with bathing. The care plan, dated 2/28/22, indicated the resident had impairments in functional status regarding bed mobility, transfers, toileting, and eating related to CVA (cardiovascular accident) with hemiplegia. The interventions included, but were not limited to, mobility bars to bed (dated 8/12/23), keep nails trimmed (dated 5/1/23); and the resident required set up and assist with eating, stand up lift assist with transfers, assist with bed mobility, and assist with toileting requiring 1 to 2 person staff assistance. Therapy to evaluate and treat as needed and ordered and encourage the resident to be as independent as safely as possible (dated 2/28/22). Review of the Point of Care History indicated the following: - September - the resident received a shower on 10/19/23 at 10:16 a.m. The documentation indicated he received a bed bath the rest of the days. - October - the resident had a shower on 10/16/23 at 7:38 p.m. The documentation indicated the received a bed bath the rest of the days. - November the resident received bed baths and no showers were documented. During an interview on 11/27/23 10:26 a.m., the resident's family member indicated Hospice did not give the resident her bath and the facility didn't either on Friday. She had to wait until the		**the potential to be affected by the same deficient practice will be identified and what corrective action(s)will be taken?** All dependent residents have the potential to be affected by the deficient practice. DHS conducted an audit of all dependent residents to ensure showers and/or baths were completed. 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 dependent residents in CCM to ensure they have received their shower and/or bath of their preference on their scheduled shower day 5x/week x 4 weeks, 3/weeks x 3 months, and 1x/week x 2 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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	following week to get a bath. During an interview on 11/29/23 at 10:00 a.m., the DHS (Director of Health Services) indicated the residents were to receive two showers a week. She did not know why the Resident 8 wasn't getting his showers. During an interview on 11/30/23 at 8:42 a.m., the DHS indicated when hospice wasn't available to give the resident a shower the facility should give the resident a shower. During an interview on 12/1/23 at 12:02 p.m., the Corporate MDS Support Nurse indicated she did not know why Resident 8 wasn't getting his showers. The residents should be getting a shower two times a week. 2. The clinical record for Resident 22 was reviewed on 11/27/23 at 10:26 a.m. The diagnoses included, but were not limited to, surgical aftercare following surgery; diverticulitis of the small intestine with perforation and abscess without bleeding; perforation of the intestine; heart disease; interstitial pulmonary disease; unspecified dementia; psychotic disturbance; mood disturbance; anxiety; abnormalities of gait and mobility cognitive communication deficit; difficulty in walking; muscle weakness; and unsteadiness on feet. The Quarterly MDS (Minimum Data Set) assessment, dated 8/24/23, indicated the resident rarely or never understood. The resident was dependent for all (ADL's) activities of daily living. The care plan, dated 9/28/22, indicated the resident had impairments in functional status regarding bed mobility, transfers, toileting, and			

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	eating related to dementia. Interventions included, but were not limited to, stand assist lift, the resident required set up and assistance with eating, 1 to 2 staff assistance with transfers, 1 to 2 staff assistance with bed mobility, and 1 to 2 staff assistance with toileting, medications per physician order, therapy to evaluate and treat as needed and ordered, encourage the resident to be as independent as safely as possible. The nurse's note, dated 11/25/23 at 2:40 p.m., indicated the resident's family member reported that the hospice aide did not show up to bath the resident. The nurse spoke with the hospice Clinical Director, and she indicated the CNA staff were not available on the weekends, but they would be in on Monday. The nurse's note, dated 6/20/23 at 2:56 p.m., indicated the resident's family member requested the resident to have a shower on Mondays in addition to Hospice aides giving a shower on Wednesday and Friday. During an interview on 11/30/23 at 3:10 p.m., the Hospice Clinical Manager indicated the CNA (Certified Nurse Aide) did not see the Resident 22 on 11/24/23 for her shower. The facility called on Saturday the 25th and she talked to the nurse and told her hospice did not have any CNA's working the weekends and the CNA would be back next week. The facility should give the residents a shower if a hospice CNA was not available. During an interview on 12/1/23 at 11:30 a.m., CNA 6 indicated the residents should get a shower two times a week. She did not know why the resident had not received her showers. During an interview on 12/1/23 at 11:35 a.m., CNA			

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	155849	A. BUILDING 00 B. WING	12/04/2023

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	5 indicated if hospice was unable to give the residents a shower the facility CNAs should do the shower. The Guidelines for Bathing policy, included, but was not limited to, "...4. Bathing shall occur at least twice a week unless resident preference states otherwise..." 3.1-38(a)(3)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review, and interview, the facility failed to ensure a resident received adequate supervision and interventions were properly implemented to prevent accidents for 2 of 3 residents reviewed for accidents. (Residents 8 and 23) Findings include: 1. The record for Resident 8 was reviewed on 11/28/23 at 8:15 a.m. The diagnoses included, but were not limited to, acute cholecystitis; ataxia following cerebral infarction occlusion and stenosis of left vertebral artery; type 2 diabetes mellitus; attention-deficit hyperactivity disorder; shortness of breath; lack of coordination; abnormalities of gait and mobility; unsteadiness	F 0689	**1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** No adverse effects occurred to residents #8 and #23 due to alleged deficient practice. Immediate corrective action was to update the care plan for both residents with appropriate fall interventions. **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**	12/22/2023

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	on feet; difficulty in walking; muscle weakness; and hemiplegia affecting the right dominant side. The Quarterly MDS (Minimum Data Set) assessment, dated 11/5/23, indicated the resident was moderately cognitively intact. He required maximum assistance for ADL's (Activities of Daily Living). The care plan, dated 8/29/22 and revised on 2/22/23, indicated the resident was at risk for falls related to decreased mobility, weakness, a history of falls and impulsive. The interventions included, but were not limited to, make sure the resident was centered in bed prior to turning onto his side (dated 7/3/23), use a stand-up lift (date 4/12/23), two staff assistance with a walker, a dycem to his wheelchair, therapy to evaluate and treat as needed, staff to provide assistance with transfers, assure the floor was free of liquids and foreign objects, keep personal items and frequently used items within reach, keep the call light in reach and encourage and assist the resident to assume a standing position slowly (dated 2/22/23). The IDT (Interdisciplinary Team) note, dated 2/6/23 at 10:17 a.m., indicated Resident 8 fell on 2/4/23 at approximately 5:00 p.m. The resident was standing in front of his recliner to be changed with one staff assistance prior to the fall. His legs gave out and he was assisted to the floor. A full body assessment was completed at the time of the incident. The resident had no apparent injuries. The IDT felt that the root cause of the fall was 1 staff assistance without a walker in front of the resident. The interventions would be 2 staff members to assist and walker in front of resident when standing. The IDT note, dated 4/12/23 at 9:35 a.m., indicated		**taken?** All residents with falls have the potential to be affected by the deficient practice. DHS conducted an audit of fall interventions for all in house residents to ensure interventions are in place. DHS in-serviced all nursing staff on accident policy and process for obtaining fall interventions in the profile care guide. **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 new resident falls in CCM to ensure profile care guide and care plan is updated to reflect new fall interventions 5x/week x 4 weeks, 3x/week x 3 months, and 1x/week x 2 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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	the resident had a fall on 4/11/23 at approximately 12:01 p.m. Staff were changing the resident related to an incontinent episode using the stand assistance aid when the resident started to sit down. Staff encouraged the resident to allow them to put a wedge behind him, but he wouldn't allow them to, and staff assisted him to the floor. No injury was observed, he did not hit his head. The immediate and continuing intervention would be to use the stand-up lift. IDT felt that the root cause was that the resident was getting weaker in his legs and not to able to hold himself up to be changed. IDT also spoke with therapy and they felt he was becoming weaker. The nurse's note, dated 4/19/23 at 9:47 p.m., indicated staff were to provide assistance with the sit to stand with a sling used for transfers. The nurse's note, dated 5/15/23 at 6:28 p.m., indicated the resident was having difficulty standing in the stand-up lift for a long amount of time. The nurse's note, dated 6/30/23 at 11:34 p.m., indicated a staff member came and got the nurse and alerted her that the resident was on the floor. She observed the resident lying flat and face down on the floor. Per a staff member, the resident had been getting a bed bath and was rolled onto his side and slipped off the side of the bed. He couldn't hold himself up so went down on his bilateral knees to the floor. From there staff assisted the resident to a more comfortable position until assistance arrived. She was informed the resident did not hit his head. He denied pain or discomfort from the fall. An abrasion was observed to his right and left knee. Multiple staff members were able to assist the resident up per a Hoyer (full body) lift and back			

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	into the bed. The new intervention was to make sure the resident was centered in the bed prior to turning onto his side. The IDT note, dated 8/28/23 at 9:48 a.m., indicated the resident rolled out of bed onto the floor while trying to get out of bed. Staff reported he stated that he had his light on but did not want to wait for help. The resident rolled over and fell out of the bed onto his blanket. Resident 8 was impulsive. The immediate intervention was to put the resident in recliner. The long term intervention was to get the resident out of bed prior to breakfast. During an interview on 11/30/23 at 12:30 p.m., RN 11 indicated the fall interventions included the call light within reach, clutter free rooms, gripper socks, personal items within reach, toileting, incontinent care, and turning and repositioning every 2 hours. During an interview on 12/1/23 at 9:30 a.m., the Physical Therapy Director indicated she was aware the resident had three falls with staff in the room. The resident was seen by physical therapy from January to June of 2023. In May nursing did not send a referral to evaluate the resident for weakness. If they had received a referral the plan of care would be updated, and goals added. Nursing sent a referral to physical therapy in September and the resident was updated to a Hoyer lift for transfers. At 9:55 a.m., the Physical Therapy Director indicated the resident was already on the therapy schedule in May. They like to keep the resident as independent as possible but in September the resident started using a Hoyer Lift due to his weakness. The resident progressed from a sit to stand, then a sling was added to the sit to stand and then he progressed			

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	to a Hoyer Lift. The resident was able to stand with one staff assistance in February. His legs gave out and he was lowered to the floor by staff. The resident's new intervention at that time was changed to a two staff assistance. The resident had another fall on 4/11/23. The new interventions included using the sit to stand with a sling. She did not know if there were 2 staff members assisting the resident or if there was just one staff member. On 8/30/23 the resident rolled out of bed onto the floor. The DHS indicated the resident had just received a new mattress and he rolled over too far and fell out. She did not think a staff member was in the room with the resident and he rolled out on his own. The resident was switched to a Hoyer lift in September. 2. The record for Resident 23 was reviewed on 11/29/23 at 10:09 a.m. The diagnoses included, but were not limited to, Parkinsonism, dementia, osteoarthritis, repeated falls, difficulty in walking, unsteadiness on feet, and muscle weakness. The Admission Observation, dated 2/17/23, indicated one of the resident's baseline care plan goals was to remain safe and free of major injury related to falls and elopement risk. Desired approaches included, non-skid footwear, proper fitting shoes, assess resident for normal routine, and do not leave unattended in the bathroom. The Fall event, dated 2/18/23 at 4:44 a.m., indicated the resident fell in the hallway and had no shoes on. The Admission MDS (Minimum Data Set) assessment, dated 2/23/23, indicated the resident was moderately cognitively impaired.			

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	The IDT note, dated 2/20/23 at 10:57 a.m., indicated the resident had an unwitnessed fall on 2/18/23 at approximately 4:30 a.m. Prior to the fall, the resident had been resting in bed. Staff observed the resident sitting on floor in front of door way to room. The resident was unable to tell staff what he was doing, as he had dementia. The IDT felt the root cause was the resident not having any socks or shoes on. The new intervention would be to offer and assist with putting on gripper socks at night. The care plan was reviewed and updated. The care plan, initiated on 2/20/23 and last revised on 11/17/23, indicated the resident was at risk for falls related to weakness, Parkinson's, history of falls, diagnosis, and impaired mobility. The intervention, dated 2/20/23, indicated to provide non-skid footwear. The Fall Event, dated 6/28/23 at 5:44 a.m., indicated the resident fell while toileting. He'd had recent confusion and would be tested for a UTI (urinary tract infection). The IDT note, dated 6/28/23 at 9:48 a.m., indicated they were waiting a response from the night shift note regarding a fall. On 6/28/23, the resident's risk for falls care plan was updated with new interventions for a medication review and obtaining laboratory testing. The IDT note, dated 6/29/23 at 11:14 a.m., indicated the resident had an unwitnessed fall on 6/28/23. Prior to the fall, the resident had been in bed. The resident got up to go to the bathroom. The resident fell in the bathroom. The resident reported hitting his head and had a small cut with			

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	a scant amount of bleeding above his left eye. First aid was performed and neurological checks were initiated. The immediate intervention was to put the resident back to bed. The IDT made the physician aware of recent discontinuation of a medication and it was restarted, and staff were to ensure the resident was wearing non-slip footwear when up. The care plan was not updated with the intervention to ensure the resident was wearing non-slip footwear when up. The IDT note, dated 11/8/23 at 2:11 p.m., indicated the resident had a non-witnessed fall on 11/5/23 at approximately 9:26 p.m. Prior to the fall, the resident had been in his room. Staff observed the resident on the floor in the bathroom. The resident had an abrasion to his right outer knee which was cleansed. Bacitracin and a dressing were applied. The IDT felt the root cause of the fall was the resident slipping while going to the restroom. The new intervention was to offer non-skid socks. On 11/8/23, the care plan was updated with an intervention to offer non-skid socks. During an observation on 11/27/23 at 7:50 a.m., Resident 23 was resident abed with normal socks on his feet. He did not have on non-skid socks or shoes. During an interview on 11/30/23 at 2:46 p.m. RN 11 indicated when a resident had a fall, the nurse was to assess them, notify family and the physician, initiate neurological checks if the fall was unwitnessed or the resident hit their head, and open a fall event. They would document the environment and do what they could to figure out the root cause of the fall.			

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	During an observation on 11/30/23 at 2:33 p.m., Resident 23 was resting abed. He was wearing a pair of tan, normal socks and was not wearing any shoes. During an observation on 12/1/23 at 11:00 a.m., Resident 23 was resting abed. He had normal socks in place and was not wearing any shoes. He indicated he'd not heard of gripper socks before. During an observation on 12/1/23 at 11:00 a.m., CNA (Certified Nurse Aide) 6 looked in the resident's room and could not locate any non-skid or gripper socks. His top draw was full of socks, none of which had non-skid bottoms on them. During this observation the resident voiced that he did not have any gripper socks if that was what the CNA was looking for. During an interview on 12/1/23 at 11:05 a.m., CNA 6 indicated she took care of Resident 23. She'd heard about a couple of his falls. He said he lost his balance. She did not know if he had any gripper socks, he normally wore shoes. She did not know where he kept his socks. She had not asked him to wear the non-skid socks before and did not know if they'd ever offered them. She could not recall seeing him with any. During an interview on 12/1/23 at 2:53 p.m., the DHS (Director of Health Services) indicated most of the resident's falls had been due to unsteadiness, he had not had any major fall. The IDT looked at the root cause and investigated the falls to determine interventions. When he was up the non-skid socks were definitely appropriate. If the fall was because he was slipping and he didn't have them on then obviously they were not ensuring them. CNA's needed to make sure they			

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	were on when the resident got out of bed. During an interview on 12/1/23 at 3:12 p.m., CNA 15 indicated she had not ever put gripper or non-skid socks on the resident. His family member usually dressed him. No one had ever asked her to ensure he had gripper socks on. She was not personally checking him during her shift to ensure he had them on and she was not aware it was one of his fall interventions. He had regular socks. Nurses were supposed to tell the CNAs his interventions. The Falls Management Program Guidelines policy, included but was not limited to, "Procedure... b. Care plan interventions should be implemented that address the resident's risk factors. 2. Should the resident experience a fall the attending nurse shall complete the 'Fall Event' This includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce risk of repeat episode and a review by the IDT to evaluate thoroughness of the investigation and appropriateness of the interventions..." 3.1-45(a)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure appropriate pain management	F 0697	1 **What corrective action will be accomplished for those**	12/22/2023

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	related to standards of practice for administering narcotic pain medication as prescribed for 1 of 5 residents reviewed for pain management. (Resident 13) Findings include: The record for Resident 13 was reviewed on 11/28/23 at 2:00 p.m. The diagnoses included, but were not limited to, fibromyalgia, right lower quadrant pain, chronic bladder pain, pain in left knee, and systemic lupus erythematosus. The Quarterly MDS (Minimum Data Set) assessment, dated 8/25/23, indicated the resident was cognitively intact, experienced mild pain, and was on a scheduled pain medication regimen. The physician's order, dated 10/25/23, indicated the resident was to receive hydrocodone 10/325 mg (milligrams) four times daily for pain. The scheduled times were between 6:00 a.m. and 10:00 a.m., between 11:00 a.m. and 1:30 p.m., between 4:00 p.m. and 7:00 p.m., and between 8:00 p.m. and 11:00 p.m. The orders lacked documentation of any parameters for how far apart to administer the doses. The October MAR for the resident's hydrocodone-acetaminophen 10/325 indicated the following: - On 10/21/23 at 7:58 p.m., the 8:00 p.m. to 11:00 p.m. dose was administered early due to the resident's request. - On 10/22/23 at 7:59 p.m., the 8:00 p.m. to 11:00 p.m. dose was administered early due to the resident's request.		**residents found to have been affected by the deficient practice?** Immediate corrective action was taken for resident #13 in which specific time frames were implemented and updated on the order per MD recommendation. **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?** DHS completed an audit for correct parameters of the order times of all residents who receive narcotic medications. Any deficient practice identified was corrected. DHS in-serviced all nursing staff on appropriate order parameters for narcotic medication administration, as well as policy to receive an order from MD to provide early administration. 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 new orders for narcotic pain medication, as well as the Medication Administration Record of 4 current residents for early administration of narcotic in CCM, 5x/week x 4 weeks, 3/week x 3 months, and 1x/week x 2 months. 4 **How the corrective**	

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	The resident's Controlled Drug Use Record Sheet, dated 10/15/23, indicated the following: - On 10/21/23 at 4:00 p.m., the resident received a dose of hydrocodone-acetaminophen 10/325 mg. - On 10/21/23 at 8:00 p.m., the resident received a dose of hydrocodone-acetaminophen 10/325 mg. - On 10/22/23 at 5:48 p.m., the resident received a dose of hydrocodone-acetaminophen 10/325 mg. - On 10/22/23 at 8:00 p.m., the resident received a dose of hydrocodone-acetaminophen 10/325 mg. The November MAR for the resident's hydrocodone-acetaminophen 10/325 mg indicated the following: - On 11/5/23 at 6:38 p.m., the 8:00 p.m. to 11:00 p.m. dose was administered early due to the resident's request. - On 11/17/23 at 6:52 p.m., the 8:00 p.m. to 11:00 p.m. dose was administered early due to the resident's request. - On 11/18/23 at 6:49 p.m., the 8:00 p.m. to 11:00 p.m. dose was administered early due to the resident's request. - On 11/22/23 at 6:51 p.m., the 8:00 p.m. to 11:00 p.m. dose was administered early due to the resident's request. - On 11/25/23 at 3:37 p.m., the 4:00 p.m. to 7:00 p.m. dose was administered early due to the resident's request. The resident's Controlled Drug Use Record Sheet, dated 10/30/23, indicated the resident received doses of hydrocodone-acetaminophen 10/325 mg on 11/5/23 at 5:00 p.m. and 7:00 p.m. The resident's Controlled Drug Use Record Sheet for hydrocodone-acetaminophen 10/325 mg, dated		**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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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
	11/12/23, indicated the following: - On 11/17/23 the resident received doses of the medication at 1:30 p.m., 5:00 p.m., and 8:00 p.m. - On 11/18/23 the resident received doses of the medication at 5:00 p.m. and 8:00 p.m. - On 11/22/23 the resident received doses of the medication at 2:00 p.m., 5:00 p.m., and 8:00 p.m. - On 11/24/23 the resident received doses of the medication at 5:00 p.m. and 8:30 p.m. - On 11/25/23, the resident received doses of the medication at 11:00 a.m. and 4:00 p.m. - On 11/26/23, the resident received doses of the medication at 5:45 p.m. and 8:00 p.m. - On 11/27/23, the resident received doses of the medication at 5:00 p.m. and 8:00 p.m. The record lacked documentation of any notification to the physician or approval from the physician for the early administrations of the resident's hydrocodone-acetaminophen 10/325 mg. During an interview on 11/30/23 at 2:51 p.m., RN 11 indicated narcotics that were written for four times a day usually had set times to administer them. If a resident requested to have a medication early she would have to get an ok from the doctor for any medications at all. She would document it in the notes of the medication or in the progress notes. If a narcotic was given four times daily, it could be concerning if they were administered too closely together. If one person gave it towards the end of the time frame and another at the beginning they would run the risk of giving them too close together. The risks with giving them too close together included oversedation, increased risk for falls, changes in mental status and activities of daily living.			

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	During an interview on 12/1/23 at 9:41 a.m., the resident's physician indicated for anyone with pain medication the timing should not be too close together. Staff could over dose them if given too close together. If giving a medication four times daily, he would not want it to be given closer than 4 hours apart. If the doses were spread out there was a more steady level of the medication in the body. He expected staff to contact him if a resident requested an early administration and he did not recall any recent incidents where he'd been contacted or authorized an early administration. During an interview on 12/1/23 at 10:03 a.m., the Director of Health Services (DHS) indicated if a medication was being given four times daily the resident should be receiving it every six hours. She was not aware of the resident receiving early administrations. The Medication Administration Times Procedural Guidelines policy, included but was not limited to, "... 2. Unless a specific time is designated by the attending physician medications shall be administered at the following times... d. QID [four times daily] - In the morning, around lunch time, around dinner time, and at bedtime... f. The nurse shall give the resident options of administration to ensure appropriate spacing of administration. i.e.: 'Would you like to stay up a little longer or shall I wake you up in an hour to give you your medication?'..." 3.1-37(a)			
F 0727 SS=E Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under			

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	paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on record review and interview, the facility failed to schedule 8-hour consecutive RN coverage for 5 of 8 months reviewed. (April, May, June, August and October 2023). This deficiency had the potential to affect all 36 residents currently residing in the facility. Findings include: Review of the April to December 2023 Licensed Nursing schedule indicated the following days were short of 8 hours consecutive RN coverage: - On 4/1 (Saturday) only 6.25 hours, - On 4/2 (Sunday) only 6.25 hours, - On 4/15 (Saturday) only 6 hours, - On 4/16 (Sunday) only 6 hours, - On 4/29 (Saturday) only 6 hours, - On 4/30 (Sunday only 6.5 hours. - On 5/13 (Saturday) only 6 hours, - On 5/27 (Saturday) only 7.75 hours, - On 5/28 (Sunday) only 6.0 hours. - On 6/10 (Saturday) only 5.5 hours.	F 0727	1 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Immediate corrective action was taken, and the current pay cycle schedule was reviewed to ensure at least 8 hours of consecutive RN coverage was provided. No adverse effects occurred due to this 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 have the potential to be affected by this deficient practice. ED in-serviced DHS and scheduler on consecutive daily RN coverage requirements. 3 **What measures will be put into place, and what systemic changes will be made to**	12/22/2023

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	- On 8/12 (Saturday) only 6 hours, - On 8/26 (Saturday) only 6 hours. - On 10/7 (Saturday) only 6 hours, - On 10/8 (Sunday) only 6 hours. During an interview on 11/27/23 at 10:00 a.m., the Executive Director (ED) indicated there were no nursing waivers. During an interview with the ED on 12/1/23 at 3:15 p.m., she indicated they thought they had it all covered. 3.1-17(b)(3)		**ensure the deficient practice does not recur?** As a measure of ongoing compliance DHS or designee will audit schedule for 8 hours of consecutive RN coverage in CCM 5x/week x 4 weeks, 3x/week x 3 months, and 1x/week x 2 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.	
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on record review and interview, the facility failed to ensure behavioral care plans were updated to reflect allegations of suicidal	F 0740	1 **What corrective action will be accomplished for those residents found to have been**	12/22/2023

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	statements and physical aggression for 1 of 5 residents reviewed for behavioral care. (Resident 23) Findings include: The record for Resident 23 was reviewed on 11/29/23 at 10:09 a.m. The diagnoses included, but were not limited to, Parksinsonism, dementia with behavioral disturbance, Parkinson's disease, and major depressive disorder. The care plan, initiated on 4/27/23 and last revised on 11/3/23, indicated the resident had altered behaviors included a history of delusions. The interventions included, but were not limited to, administer medications per orders, monitor the resident's behaviors with all hands on care and contacts, and psychiatric services as needed (all initiated on 4/27/23). The late entry nurse's note, authored on 7/27/23 at 9:52 a.m., was dated for 7/26/2023 at 6:20 p.m., indicated the resident's family member came to the DHS (Director of Health Services) and reported he was trying to scare her by saying he was going to jump off a bridge. The DHS spoke to the resident who denied saying that and said the family member didn't know what she was talking about. The resident denied thoughts or any plan. The SSD (Social Services Director) and ED (Executive Director) were notified. The SSD note, dated 7/27/23 at 12:48 p.m., indicated the resident denied thoughts of harming himself. The psychiatric NP (nurse practitioner) would be in the following week and would see the resident. The late entry nurse's note, authored on 7/31/23 at		**affected by the deficient practice?** Immediate corrective action was that care plan for resident #23 was updated with appropriate behavior interventions. 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 behavioral health services have the potential to be affected. Social Services Director conducted an audit of all residents who have a need for behavioral health services have an appropriate care plan in place. DHS in-serviced all nursing and social services staff on behavioral health policy. 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 review all new or worsening behavioral events in CCM to ensure appropriate Care Plan in place 5x/week x 4 weeks, 3x/week x 3 months, and 1x/week x 2 months. 4 **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** As a quality measure, the	

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	11:19 p.m. and dated for 7/28/23 at 11:19 p.m., indicated the resident's family member came to the author in tears, indicating the resident had put his hand around her neck and squeezed. The resident had thought his family member was going to take him out of the facility that day, however it was going to be the following day. The resident became upset and told his family member he just wanted to strangle her, he then put his hand around her neck and squeezed. The SSD was notified. The physician had come in to see the resident, however his family member had taken him out to dinner in hopes of calming his anger down. She was advised to not take the resident out by facility staff, however she said she knew he would not hurt her and was just trying to make her feel bad. Staff told her to ensure she had a safe number to call and to call 911 if needed. The psychiatric NP would re-evaluate the resident. During an interview on 11/30/23 at 2:46 p.m., RN 11 indicated if a family member presented with concerns of a resident expressing self harm or harm to others, the resident would be placed in 1 on 1 and notify the doctor. She would monitor them at least for 72 hours if not longer. Social services would be notified as well. During an interview on 12/1/23 at 10:25 a.m., the SSD indicated anytime a resident made a statement like that she would go and see them and see if they had a plan. She would notify the doctor. Resident 23 had made several statements, however he could not get to a bridge and the windows did not open up to where he could jump out and harm himself. She did not see any increased monitoring after the family member reported the statement. The resident was known for making those kinds of statements. He was angry with his family member and said things to		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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	her. She did not come in as frequently, she usually visited in open spots. She did not see any care plans for suicidal statements or behaviors towards his family member. During an interview on 12/1/23 at 10:50 a.m., the DHS indicated if there was a true concern, the Interdisciplinary team would get involved right away. She always made sure the family member had a safety number and that she had someone she felt safe with if she was taking him out. She made sure she kept the call light in reach when in the room. They were aware he had behaviors towards the family member. She did not document the safety plan or the call light intervention, she had just talked with the family member about it. They would want that information on his care plan. During an interview on 12/1/23 at 11:00 a.m., CNA (Certified Nurse Aide) 6 indicated she was not aware of Resident 23 having any behaviors towards others, then indicated she was aware of concerns with his behavior towards his family member. The family member had told her something about him being a little aggressive. She was not aware of any history of the resident making statements of self harm or harm to others. She was not aware of instances of aggression until after the fact. No one had ever discussed with her specific interventions for that type of behavior. If she witnessed the behavior she would try to calm him down and ask her to leave the room, that way they could get him calmed down, and then she would let the nurse know so they could make an event and further investigate it. During an interview on 12/1/23 at 11:18 a.m., RN 3 indicated she was not aware of any behavioral issues with the resident. She had heard some stuff			

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	from his family member, like that people were breaking into the house and that it was exhausting, but was not aware of any history of self harm statements. She was not aware of any history of physical or verbal aggression towards the family member. She would expect to see it on the care plan. The Guidelines for Mental Health Wellness Program policy included, but was not limited to, " ... If behavior concerns are identified a baseline Behavior Plan of Care shall be developed. a. The plan of care shall address the identified root cause of the behaviors. 4. Behavior interventions shall be communicated to the interdisciplinary team for implementation ..." 3.1-37(a)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed			

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	compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review, and interview, the facility failed to ensure proper storage and disposal of medications for 2 of 2 medication storage rooms reviewed for medication storage. (200 A Hall Medication Room and 200 B Hall Medication Room) Findings include: 1. During an observation on 11/30/23 at 12:13 p.m., of the 200 A Hall Medication Storage Room with RN 11 the following concerns were observed: - In the refrigerator there was one bottle of Humulin R injection solution 100 units/mL which indicated a staff members name as the recipient. - In a basket in the cabinet under the right side of the sink there were three unlabeled bottle of nystatin 100,000 units per gram powder, and one container of magic butt cream with a partially destroyed label, which indicated it was prepared on 2/11/22 and best used by 8/11/22. - In a clear bag there were several tubes of topical creams, including 1 open tube of mupirocin 2% cream, 2 tubes of venelex ointment, and 1 open tube of metronidazole gel 0.75%, and one bottle of nystatin powder. There were no labels on any of the medications. During an interview on 11/30/23 at 12:15 p.m., RN 11 indicated she thought the topical treatments in the bag belonged to a resident who was no longer	F 0761	1 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. Immediate corrective action was to remove all non- resident medications, expired medications, and discharge residents' medications from medication rooms. 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 have the potential to be affected by the alleged deficient practice. DHS inspected all med rooms to ensure non-resident, expired medications, and discharged resident's medications were not in those rooms. 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	12/22/2023

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	at the facility and had been discharged for a few weeks. Medications were usually destroyed within a few days of discharge, all of the medications which were unlabeled in the 200 A Hall Medication Storage Room should have been pulled and destroyed or discarded by now. 2. During an observation on 11/30/23 at 12:29 p.m. with LPN (Licensed Practical Nurse) 16 of the 200 B Hall Medication Storage Room, the following concerns were observed: - In a cabinet above the sink there was one unlabeled bottle of ceftriaxone 1 gram for injection. LPN 16 indicated the medication should be in the Pyxis as it was not a house stock medication and did not belong to any residents. She was not sure why it was in the cabinet. - In a drawer under the sink, there was an opened bottle of Tums with the label ripped off. LPN 16 indicated she did not know who the medication belonged to. - In the freezer there was no thermometer to measure the temperature. - In a file shelf against the wall was a very old looking discolored storage bag. Inside the bag was an opened, unlabeled bottle of aspirin 325 mg, one bottle of allopurinol 100 mg tablets which was dated 9/4/22 with a use by date of 9/4/23 which which was nearly full, one bottle of omeprazole 20 mg which was dated 9/13/22, with a use by date of 9/13/23. The medication bottles indicated they belonged to Resident 19. The record for Resident 19 was reviewed on 11/30/23 at 1:00 p.m. The diagnoses included, but were not limited to, arthritis, crystal arthropathy, gout, and diversticulosis. The physician's orders, indicated the resident		compliance DHS or designee will inspect medication rooms 5x/week x 4 weeks, 3x/week x 3 months, and 1x/week x 2 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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	received the following medications: - Allopurinol 100 mg twice daily for gout which started on 10/6/22. - Aspirin 81 mg daily, which started on 4/26/23. - Pantoprazole 40 mg daily, which started on 9/11/23. Resident 19 did not have current orders for omeprazole or aspirin 325 mg, During an interview on 11/30/23 at 12:35 p.m. LPN 16 indicated the bottles in the bag were Resident 19's home medications she had admitted with. If there were expired and had come from the pharmacy they would be sent back, but she was not sure on the process for a resident's home medications. During an interview on 11/30/23 at 12:51 p.m., the Director of Health Services (DHS) indicated the unlabeled medications in the medication storage rooms were not house stock medications. Medications should be cleaned out regularly. They did have Resident 19's medications in the medication storage room. She would see if the resident would let her dispose of it now since it was expired. She did not know where the freezers thermometer was, the only thing she could think is they'd had a resident have a new fridge and maybe they used that one and put it in hers. She would be having one put in there that day. They should not have unlabeled medications in the cupboard. The Medication Storage in the Facility policy, included, but was not limited to, "... C. All medications dispensed by the pharmacy are stored in the container with the pharmacy label... F. Medications labeled for individual residents are stored separately from floor stock medications			

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	when not in a medication cart... H. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal... G... All expired medications will be removed from the active supply and destroyed in the facility regardless of amount remaining..." 3.1-25(j) 3.1-25(o)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure survey. Survey dates: November 27, 28, 29, 30, December 1 and 4, 2023. Facility number: 013535 Residential Census: 23 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 December 10, 2023.	R 0000	Submission of this 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 quality of 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 hereby 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 December 4, 2023. We initiated	

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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
			immediate interventions when concerns were identified on this date. We respectfully request a paper 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	