

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155849	X2) MULTIPLE CONSTRUCTION A. BUILDING -- _____ B. WING _____	X3) DATE SURVEY COMPLETED 01/03/2024
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NAME OF PROVIDER OR SUPPLIER RIVER TERRACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 120 PRESBYTERIAN AVE MADISON, IN 47250
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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/03/24 Facility Number: 013535 Provider Number: 155849 AIM Number: 300018660 At this Emergency Preparedness survey, River Terrace Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 57 certified beds. At the time of the survey, the census was 31. Quality Review completed on 01/04/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/03/24 Facility Number: 013535 Provider Number: 155849 AIM Number: 300018660 At this Life Safety Code survey, River Terrace Health Campus was found not in compliance with	K 0000	The 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 it's obligation to provide legally and medically necessary care and services to its residents in an economic and	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rhonda Gibson	Executive Director	01/18/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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K 0353 SS=B Bldg. 01	<p>Requirements for Participation in Medicare, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This facility was located on the first and second floors of a four story building with a basement and was determined to be of Type I (332) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and in all resident sleeping rooms. The facility has a capacity of 57 and had a census of 31 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered, and all areas providing facility services were sprinklered, except two detached buildings housing the facility's emergency generators.</p> <p>Quality Review completed on 01/04/24</p> <p>NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p>		efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. Attached you will find our Plan of Correction for River Terrace Health Campus, and we respectfully request paper compliance be accepted after review of the plan of correction along with monitoring tools.		

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	<p>c) Water system supply source</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>Based on observation and interview, the facility failed to maintain the ceiling construction in 1 first floor office, which was being used for box storage. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect 10 residents, staff, and visitors in the vicinity of the first floor office being used for box storage.</p> <p>Findings include:</p> <p>Based on observations with the Chief Engineer and Facilities Management Support during a tour of the facility from 1:45 p.m. to 3:45 p.m. on 01/03/24, four suspended ceiling tiles were missing in an office being used for box storage on the 1st floor. The room was equipped with two pendant sprinkler heads installed on the suspended ceiling. Based on interview at the time of the observations, the Chief Engineer and Facilities Management Support agreed the missing ceiling tiles would delay sprinkler activation in the first floor office being used for box storage.</p> <p>This finding was reviewed with the Chief Engineer and the Facilities Management Support at the exit</p>	K 0353	<p>1 The Chief Engineer put the ceiling tiles back into the appropriate places in the ceiling (see attached photos).</p> <p>2 No other residents had the potential to be affected by this alleged deficit. The Chief Engineer and maintenance staff conducted a walk through to identify any other missing ceiling tiles.</p> <p>3 The Chief Engineer and maintenance support were educated by the Executive Director on K353 to ensure that distance between the sprinkler deflector and the ceiling above. The Chief Engineer or designee will complete a walkthrough of the facility 5x/week x 1 month, 1x/week for 2 months to ensure that all ceiling tiles are in the appropriate location, and no sprinklers have the potential to be delayed. Results of these audits will be presented by the Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved</p>	01/18/2024
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K 0712 SS=F Bldg. 01	<p>conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Fire Drills Fire Drills</p> <p>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.</p> <p>19.7.1.4 through 19.7.1.7</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills on the third shift for 1 of 4 quarters. This deficient practice affects all staff and residents.</p> <p>Findings include:</p> <p>Based on review of "Fire Drills" documentation with the Chief Engineer and the Facilities Management Support during record review from 10:45 a.m. to 1:45 p.m. on 01/03/24, documentation of a third shift fire drill conducted in the fourth quarter of 2023 was not available for review. Based on interview at the time of record review, the Chief Engineer stated the facility operates three shifts per day and agreed documentation of a third shift fire drill conducted in the fourth quarter of 2023 was not available for review.</p> <p>These findings were reviewed with the Chief Engineer and Facilities Management Support</p>	K 0712	<p>1 The Chief Engineer completed a fire drill for third shift to ensure all staff were able to participate in a fire drill.</p> <p>2 All residents have the potential to be affected by this alleged deficit. The Chief Engineer and maintenance staff have maintained all fire drills.</p> <p>3 The Chief Engineer and maintenance support were educated by the Executive Director on K712, and state guidelines related to timing of fire drills.</p> <p>4 The Chief Engineer or designee will audit to ensure fire drills are completed in accordance with state regulations 5x/week x 1 week and 1x/month x 2 months. Results of these audits will be</p>	01/18/2024

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K 0918 SS=F Bldg. 01	<p>during the exit conference.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable,</p>		presented by the Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.	

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	<p>and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>Based on observation and interview, the facility failed to ensure 2 of 3 emergency generators were maintained in accordance with the provisions of NFPA 110. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Section 7.2.1 states the Emergency Power Supply (EPS) shall be installed in a separate room for Level 1 installations or be located in an adequate enclosure located outside the building capable of resisting the entrance of snow or rain at a maximum wind velocity required by local building codes. Section 7.2.1.2 states no other equipment, including architectural appurtenances, except that service this space, shall be permitted in this room. This deficient practice could affect all residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Chief Engineer and the Facilities Management Support during a tour of the facility from 1:45 p.m. to 3:45 p.m. on 01/03/24, two of the facility's three emergency generators are located in the largest of the two separate detached buildings housing the emergency generators for the facility. Over 30 cardboard boxes containing combustible Covid-19 supplies, a mobile hot oil popcorn popping machine, ladders and other miscellaneous items were stored inside the enclosure of the largest of the two separate detached buildings housing the emergency generators for the facility. Based on interview at the time of the observations, the Chief Engineer stated the building houses emergency</p>	K 0918	<p>1 The Chief Engineer disposed of all combustible supplies in the building housing the emergency generators, as evidenced by photos attached.</p> <p>2 No residents have the potential to be affected by the alleged deficit. The Chief Engineer and maintenance staff conducted an inspection of all buildings that house emergency generators to ensure no combustible items are in the buildings.</p> <p>3 The Chief Engineer and maintenance support were educated by the Executive Director on K918 to ensure safety in emergency generator buildings.</p> <p>4 The Chief Engineer or designee will complete a walkthrough of emergency generator building 5x/week x 1 month, 1x/week for 2 months to ensure that no combustible items are present. Results of these audits will be presented by the Executive Director to the QA committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.</p>	01/18/2024
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	<p>generator #2 and #3, each generator is diesel fuel fired and agreed the enclosure for the emergency generators was also being used for storage of combustible supplies and other equipment.</p> <p>These findings were reviewed with the Chief Engineer and the Facilities Management Support during the exit conference.</p> <p>3.1-19(b)</p>				