

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 003575	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/16/2015
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NAME OF PROVIDER OR SUPPLIER RIVER TERRACE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 400 CAYLOR BLVD BLUFFTON, IN 46714
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00177007.</p> <p>Complaint IN00177007 - Unsubstantiated, due to lack of evidence.</p> <p>Survey Dates: July 14, 15 & 16, 2015</p> <p>Facility number: 003575 Provider number: 155726 AIM number: 200395060</p> <p>Census bed type: SNF/NF: 23 Residential: 54 Total: 77</p> <p>Census payor type: Medicare: 4 Medicaid: 10 Other: 63 Total: 77</p> <p>Sample: 3</p> <p>River Terrace Health Care Center was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00177007.</p>	R 000		

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