STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155726	A. BUILDING 00 B. WING	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVER TERRACE HEALTH CARE CENTER	400 CAYLOR BLVD BLUFFTON, IN 46714

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: January 6, 7, 8, 9, 10, 2025. Facility number: 003575 Provider number: 155726 AIM number: 20039506 Census Bed Type: SNF/NF: 28 Residential: 31 Total: 59 Census Payor Type: Medicare: 2 Medicaid: 21 Other: 5 Total: 28 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 13, 2025	F 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility respectfully requests a desk review be considered as our allegation of compliance to the plan of correction effective January 26, 2025, for the annual survey completed January 10, 2025.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview, and record review the facility failed to ensure labeling of open date for 1 of 1 carts reviewed. (Resident 29). Findings include: During an observation, on 01/07/25 at 9:38 AM, in the medication room with Qualified Medical Assistant 3 (QMA) and Registered Nurse 2 (RN),	F 0761	=”” div <=”” divthe=”” corrective=”” action(s)=”” accomplished=”” for=”” resident=”” found=”” to=”” have=”” been=”” affected=”” by=”” deficient=”” practice: <=”” div	01/26/2025

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

Mallory Zehr | Administrator | 02/12/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Resident 29's insulins were observed in a compartment labeled with his last name. The half full bottle of Humalog in the compartment was not labeled with an open date or any identifying information. RN 2 indicated there was no way to determine when the medication was opened, who it belionged to, and it would be discarded. A Glargine pen was labeled with an open date of 12/3/24. RN 2 indicated insulin is only good for 28 days after being removed from the refrigerator. The pen was 7 days past the 28 day expiration. RN 2 indicated the Glargine pen would be discarded. Resident 29's compartment also had a half full bottle of Lantus insulin without any labeling to indicate resident name or the opened date. RN 2 indicated there was no way to ensure when the medication was opened, who it bleonged to, and indicated the Lantus insulin would be discarded. During an interview, on 01/07/25 at 9:38 AM, QMA 3 indicated all meds were to be labeled with an open date, residents name, room number, and a discard date or expiration date. Resident 29's record review began on 01/06/25 at 11:13 AM. Resident 29's diagnoses included type 2 diabetes mellutis. Resident 29 had a physcian order for Humalog Humalog Kwik pen 100 units/ml per sliding scale four times per day. Resident 29 also had a physician order for Glargine pen 100 units/ml, inject 50units once daily, hold for blood sugar less than 120. Resident 29's Medication Administration Record			

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	(MAR) for Humalog Kwik pen indicated he received the insulin multiple times a day from January 1- January 7, 2025 after blood sugar checks at 8am, noon, 4pm, and 8pm. Resident 29's MAR for the month of January 2025 indicated he received Glargine insulin daily at 8am. A policy titled, "Medication labels", dated 5/21/2018 and reviewed 5/20/2020 was received by the Administrator on 1/7/25 at 12:51PM. The policy indicated ..."1. The labels are permanently affixed to the outside of the prescription container. If the label does not fit it can be affixed to an outside container or carton, the resident's name, at a minimum, must be maintained directly on the actual product container. 2. Each prescription medication label includes: a. Residents name. b. specific directions for use e. prescriber's name. f. date dispensed. g. quantity of the medication h. expiration date of the medication i. name, address, and telephone number of dispensing pharmacy ... 3.1-25(j)(m)(n)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on interview and record review the facility failed to document catheter output for 1 of 1 resident reviewed. (Resident 12) Findings include: Resident 12's record review began on 1/6/25 at 11:35AM, diagnoses included Neurospasmatic bladder. Certified Nursing Assistant (CNA) task charting	F 0842	It is the practice of this facility that medical records for each resident contain accurate documentation in reference to catheter output on those residents with a foley catheter. The corrective action(s) accomplished for the resident found to have been affected by the deficient practice:	01/26/2025

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	indicated Resident 12 only had one entry for urinary catheter output on the following dates, times and amounts: 12/14/24 at 9:28PM 1200ml 12/21/24 at 1:59PM 901ml 12/23/24 at 9:59PM 600ml 12/25/24 at 1:59PM 1000ml 12/27/24 at 9:59PM 2001ml 12/28/24 at 9:35PM 1100ml 12/31/24 at 1:59PM 701ml 1/4/25 at 1:59PM 1000ml 1/5/25 at 7:37PM 1500ml 1/6/25 at 1:59PM 1000ml No other entries for each shift was available for review by the time of exit. Resident 12's physician order, dated 5/3/24, indicated to give Lasix 20mg, take 1 tabled in am with a start date of 5/6/24. In an interview, on 1/7/25 at 1:37 PM, the Director of Nursing (DON) indicated the importance of keeping track of urinary output of residents with a catheter ensured the first sign of issues were addressed. The DON indicated it was especially important with Resident 12 due to her use of a diuretic medication Lasix. The DON indicated the expectation was for catheters to be emptied at the end of each shift and during routine catheter care or when bag was half full as necessary. The DON indicated education would be required if there were not at a minimum of 2 entries every day for catheter output. In an interview, on 1/7/25 at 1:42PM, CNA 4 indicated Resident 12 always required at a minimum one emptying of her catheter bag on each shift she has worked. CNA 4 indicated she did not always have time to document the output and therefore the numbers may be inaccurate at		The catheter for resident 12 was emptied and the output documented. An in-service was held with employee 4 on emptying catheters and notifying nurse of output to be documented. How are other residents having the potential to be affected by the same deficient practice identified and what corrective action (s) will be taken: All residents who have catheters have the potential to be affected by the alleged deficient practice. Physician orders were written on each resident with a catheter to transfer responsibility of documenting catheter output every shift to the licensed nurse/QMA for oversight. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The facility policy on Output, measuring and recording was reviewed by the IDT. An in-service will be conducted with all nursing staff on the policy and corrective action by 1/26/25. A performance improvement tool has been developed to monitor that physician orders are in place to document the amount of urine output every shift for all residents	

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	times. A current policy and procedure titled, "Output, Measuring and Recording" dated as revised October 2010, provided by the Administrator on 1/8/25 at 11:05am indicated ...The purpose of this procedure is to accurately determine the amount of urine that a resident excretes in a 24-hour period ...Steps in the procedure 7. Carefully observe the level of urine in the graduate. Maintain eye level so that you can see the number reached by the level of urine. 8. Record the amount noted on the output side of intake and output record. 9. Record the time the output was measured. Documentation The following information should be recorded on the bedside intake and output record and/or in the resident's medical record: 1. The date and time the resident's urine was measured and recorded. 3. The amount of output ... 3.1-50(a)		with catheters. Completion of documentation will be reviewed during morning clinical meetings. How the corrective actions will be monitored to ensure the deficient practice does not recur: A performance improvement tool has been initiated that audits documentation of urine output every shift for those residents with urinary catheters. This performance improvement tool will be completed by the Director of Nursing or designee weekly for 4 weeks, then monthly for three months, then quarterly x3. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. By what date the systemic changes for the deficiency will be completed: 1/26/25 F0761 It is the practice of this facility that Drugs and biologicals used in the facility be labeled and stored in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions and the expiration	

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			date when applicable. The corrective action(s) accomplished for the resident found to have been affected by the deficient practice: The Humalog Glargine pen and Lantus for resident 29 was removed from the cart and properly disposed of. A new supply of medication was obtained from the pharmacy. How are other residents having the potential to be affected by the same deficient practice identified and what corrective action(s) will be taken: All residents who are administered insulin have the potential of being affected by the alleged deficient practice. The insulin supply on the medication carts were reviewed to ensure labels contained information to identify the resident and open dates were present which did not exceed 28 days. No other concerns were identified. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The facility policy on Medication Labeling was reviewed by the IDT. An in-service will be conducted with all facility nurses and QMAs	

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			on the policy by 1/26/25. A performance improvement tool has been developed to monitory Medication carts to ensure insulin is properly labeled, date opened is present and does not exceed the expiration date of 28 days. How the corrective actions will be monitored to ensure the deficient practice does not recur: A performance improvement tool has been initiated that audits that insulin is properly labeled with resident identifier information and date opened and that medication has not exceeded the expiration date. This performance improvement tool will be completed by the Director of Nursing/designee weekly for four weeks; then monthly for three months; then quarterly times three quarters. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance meeting at least quarterly. By what date the systemic changes for the deficiency will be completed: 1/26/2025	
R 0000 Bldg. 00	This visit was for a State Residential Licensure	R 0000	By submitting the enclosed	

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	Survey. Survey dates: January 6, 7, 8, 9, and 10, 2025. Facility number: 003575 Residential Census: 31 River Terrace Health Care Center was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed January 13, 2025		materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility respectfully requests a desk review be considered as our allegation of compliance to the plan of correction effective January 26, 2025, for the annual survey completed January 10, 2025.	