STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155726	A. BUILDING -- B. WING	01/24/2025

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

(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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/24/25 Facility Number: 003575 Provider Number: 155726 AIM Number: 200395060 At this Emergency Preparedness survey, River Terrace Health Care Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 30 and had a census of 26 at the time of this survey. The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by: Quality Review conducted on 01/28/25	E 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 February 8, 2025 for the Life Safety survey completed January 24, 2025.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.	E 0039	1. No residents were harmed 2. All residents had the potential to be affected 3. Immediate corrective action: Administrator and maintenance staff were educated on policy relating to Emergency Preparedness and disaster training a. After action – Sprinkler pipe burst with fire watch on 1/25/25	02/08/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mallory Zehr	Administrator	02/08/2025

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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	b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director and the Administrator on 01/24/25 at 10:12 a.m., there was documentation for community drill conducted on 2/09/24 but no documentation of an additional exercise of choice was available for review. Based on an interview at the time of records review, the Maintenance Director and the Administrator stated a second drill of choice was not conducted in the last year. This finding was reviewed with the Maintenance Director and the Administrator during the exit		b. Tabletop exercise completed on 2/7/25 4. Corrective action to monitor performance to assure compliance through quality assurance: a. Training exercises have been added to TELS to ensure completion per policy. The Quality Assurance Committee reviews TELS logs to ensure compliance. This is an ongoing process. 5. The date the systemic change will be completed: 2/7/25	

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	155726	A. BUILDING -- B. WING	01/24/2025

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	conference.			
K 0000 Bldg. 01	A Life Safety Code Recertification (LSC) and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/24/25 Facility Number: 003575 Provider Number: 155726 AIM Number: 200395060 At this LSC survey, River Terrace Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, LSC, Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 30 and had a census of 26 at the time of this survey. All areas where the residents have customary access were sprinklered. The facility has a maintenance building providing facility services including maintenance supplies that was not sprinklered.	K 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 February 8, 2025 for the Life Safety survey completed January 24, 2025.	

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K 0222 SS=E Bldg. 01	Quality Review conducted on 01/28/25 NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure 1 of 2 delayed egress locking arrangements were installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect 15 residents in the long hall. Findings include: Based on observation during a tour of the facility with the Maintenance Director and Administrator on 01/24/25 at 12:55 p.m., the long hall exit door was equipped with a 15 second delayed egress. When the exit door was tested the irreversible process to release the lock was not initiated. Based on an interview at the time of observation, the Maintenance Director tried 4 times to activate the delayed egress and stated the delayed egress is not working and will need to be repaired.	K 0222	1. No residents were harmed 2. All residents had the potential to be affected. 3. Immediate corrective action: The vendor was notified and egress door was serviced and door was repaired. 4. Maintenance staff educated on policy concerning testing and requirements of egress doors. 5. Corrective action taken to monitor performance to assure compliance through quality assurance: a. Performance Improvement Audit Tool has been initiated, the Maintenance Director or designee will complete weekly audits on all facility egress doors twice weekly for 4 weeks or until 100% compliance is achieved, then weekly thereafter. b. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. 6. The date the systemic changes will be completed: 2/4/25	02/04/2025

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	This finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)			
K 0291 SS=C Bldg. 01	NFPA 101 Emergency Lighting Based on review and interview, the facility failed to maintain itemized records of the inspections and tests for 7 of 7 battery backup lights. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include: Based on records review with the Administrator and the Maintenance Director on 01/24/25 at 11:14 a.m., the "Emergency Lighting Battery Test" form indicated the battery-operated lights from July to December of 2024 were tested monthly and annual, but the form was not itemized to show that each emergency light in the facility was tested. Based on an interview at the time of record review, the Maintenance Director stated he did not document the test results for each individual light from July to December of 2024. This finding was reviewed with the Maintenance	K 0291	1. No residents were harmed 2. All residents had the potential to be affected. 3. Immediate corrective action: Maintenance staff were educated on policy and regulation regarding emergency light testing. Each, individual emergency light was labeled and tested individually and documented individually. 4. Corrective Action taken to monitor performance to assure compliance through quality assurance: a. Performance improvement audit tool has been initiated, the Maintenance Director or designee will audit Emergency Light testing monthly for 6 months and quarterly thereafter or until 100% compliance has been achieved. b. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcome of the tools 5. The date the systemic changes will be completed: 2/4/25	02/04/2025

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	Director and the Administrator during the exit conference. 3.1-19(b)			
K 0914 SS=C Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Based on record review and interview, the facility failed to ensure the testing form for the hospital grade electrical receptacles in 20 of 20 resident sleeping rooms showed that each receptacle was tested. NFPA 99, Health Care Facilities Code 2012 Edition, section 6.3.4.2.1.2 states at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This deficient practice could affect all residents. Findings include: Based on record review with the with the Maintenance Director and the Administrator on 01/24/25 at 11:12 a.m., the electric receptacle testing form dated 01/20/25 indicated only the room numbers of the receptacles tested and did not indicate which receptacle in each room have met, or have failed to meet, the performance requirements. Based on an interview during records review the Maintenance Director and the Administrator agreed the receptacle testing form only indicated the room numbers and did not indicate that each receptacle in each room was tested. This finding was reviewed with the Maintenance Director and the Administrator during the exit conference.	K 0914	1. No residents were harmed 2. All residents had the potential to be affected. 3. Immediate corrective action: Maintenance staff were educated on policy and regulation regarding receptacle testing. Each, individual receptacle was labeled and tested individually and documented individually per each resident room. 4. Corrective Action taken to monitor performance to assure compliance through quality assurance: a. Performance improvement audit tool has been initiated, the Maintenance Director or designee will audit Hospital Grade Receptacle testing monthly for 6 months and quarterly thereafter or until 100% compliance has been achieved. b. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcome of the tools 5. The date the systemic changes will be completed: 2/8/25	02/08/2025

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	3.1-19(b)			
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 1 of 1 flexible cord power-strip in a patient care location met the required UL rating of 1363A or 60601-1. This deficient practice affects two residents. Findings include: Based on observations with the Maintenance Director and the Administrator on 01/24/25 at 12:30 p.m., a power-strip in room 105 was in use within 6 feet of a resident care area that did not meet 1363A or 60601-1. Based on an interview at the time of observation, the Maintenance Director agreed the power-strip was in use in a resident care area and did not meet 1363A or 60601-1. This finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)	K 0920	1. No residents were harmed 2. 2 residents had the potential to be affected 3. Immediate corrective action: Staff were educated on policy and regulation regarding Electrical equipment and use of power strips and extension cords. a. The non-compliant power strip was removed from resident room immediately b. All resident care areas were inspected to identify any non-compliant power strips and remove if necessary 4. Corrective Action taken to monitor performance to assure compliance through quality assurance: a. Performance improvement audit tool has been initiated, the Maintenance Director or designee will perform twice weekly rounds for 4 weeks or until 100% compliance has been achieved and then weekly thereafter b. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcome of the tools 5. The date the systemic changes	02/08/2025

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			will be completed: 2/8/24	