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	03/07/2024

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: 03/07/24 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 28 at the time of this survey. Quality Review completed on 03/08/24	E 0000	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 requests that the plan of correction be considered our allegation of compliance effective March 22, 2024 for the survey completed March 7th. River Terrace Retirement Community would like to respectfully request a desk review/paper compliance of this plan of correction. p="">	
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)			

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

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	(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff),			

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	with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years.			

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	(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first			

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	workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC			

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	must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility. Findings include: Based on records review with the Administrator and the Maintenance Director on 03/07/24 at 10:49 a.m., no documentation of annual EEP training and no documentation to show staff could demonstrate knowledge of the EPP was available for review. Based on an interview at the time of records review, the Administrator stated the EPP training was not conducted within the last year. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	E 0037	E 0037 Emergency Preparedness Training Program It is the practice of River Terrace Retirement Community to train all employees upon hire and annually on emergency preparedness. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were identified as being affected by the deficient practice. All staff will be educated by March 22, 2024 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 deficient practice. An emergency preparedness training guide has been created to record the education and training of all new and existing employees. Documentation of annual and new employee orientation will be kept in that binder. What measures will be put into	03/22/2024

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			place and what systematic change will be made to ensure that the deficient practice does not recur: The emergency preparedness plan was reviewed by the administrator, maintenance director, and maintenance assistant. An in-service was conducted with all facility personnel on the policy. A performance improvement tool has been developed to monitor the required training (new and existing employees). How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: A Quality Assurance tool has been developed and implemented that randomly audits. This toll will be completed by the Administrator and/or his/her designee weekly times three, then monthly times three and then quarterly times three. In the event any further concerns are identified, the issue will be immediately corrected, and additional training will be initiated. The outcomes will be reviewed through the facility Quality Assurance Program at least quarterly. By what date the systemic changes for each deficiency will	

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			be completed: March 22, 2024	
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: 03/07/24 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 28 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	K 0000	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 requests that the plan of correction be considered our allegation of compliance effective March 22, 2024 for the survey completed March 7th. River Terrace Retirement Community would like to respectfully request a desk review/paper compliance of this plan of correction. p="">	

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	sprinklered. Quality Review completed on 03/08/24			
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on records review, observation, and interview, the facility failed to ensure 7 of 7 battery backup lights were properly tested. Section 7.9.3.1.1 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. Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice affects all residents. Findings include: Based on observation with the Administrator and the Maintenance Director on 03/07/24 between 11:00 a.m. and 12:00 p.m., in the healthcare wing there were seven battery-operated emergency lights in the halls. Based on records review at 10:40 a.m., monthly testing for the battery powered emergency lights were not conducted between March and July of 2023. Also, there was no documentation for the 90-minute annual light test. Based on an interview, the Maintenance Director confirmed the testing for the battery powered lights was not conducted due to there being no Maintenance Director during that time.	K 0291	K 291 Emergency Lighting It is the practice of River Terrace Retirement Community to test battery backup lights monthly. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were identified as being affected by the deficient practice. Maintenance staff were educated regarding monthly testing of batter backup emergency light on 3-18-24, How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will taken: All residents have the potential to be affected by the deficient practice. A Life Safety binder has been created to record the monthly battery backup test of the	03/22/2024

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	This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		emergency lights. Documentation of the test will be kept in the Life Safety binder. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The monthly testing of the battery backup of the emergency lights form was reviewed by the administrator, maintenance director and maintenance assistant. An in-services was conducted with the maintenance department on the policy on 3-18-24. A performance improvement tool has been developed to monitor required testing. How the corrective action(s) will monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: A Quality Assurance tool has been developed and implemented that randomly audits. This tool will be completed by the Administrator and/or designee weekly times three, then monthly times three and then quarterly times three. In the event any further concerns are identified, the issue will be immediately corrected, and additional training will be initiated. The outcomes	

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			will be reviewed through the facility Quality Assurance Program at quarterly. By what date the systemic changes for each deficiency will be completed: March 22, 2024	
K 0353 SS=F Bldg. 01	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. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ 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 Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection	K 0353	K 0353 Sprinkler System It is the practice of River Terrace Retirement Community to weekly test the dry pipe sprinkler system's gauges and valves.	03/22/2024

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	Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 03/07/24 at 10:13 a.m., there was no weekly inspection of the dry pipe sprinkler system's gauges and valves for the months of April to July of 2023. During an interview at the time of record review, the Maintenance Director stated the inspection of gauges and valves were not conducted due to there being no Maintenance Director during that time. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were identified as being affected by the deficient practice. Maintenance staff were educated regarding weekly testing of the dry pipe sprinkler system's gauges and valves on 3-18-24. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will taken: All residents have the potential to be affected by the deficient practice. A Life Safety binder has been created to record the weekly dry pipe sprinkler system's gauges and valves. Documentation of the test will be kept in the Life Safety binder. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The weekly testing of the dry pipe sprinkler system's gauges and valves was reviewed by the administrator, maintenance director and maintenance assistant. An in-service was conducted with the maintenance	

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			department on the policy on 3-18-24. A performance improvement tool has been developed to monitor required testing. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: A Quality of Assurance tool has been developed and implemented that randomly audits. This tool will be completed by the Administrator and/or his/her designee monthly times three, then quarterly times three, then semi-annually. In the event any further concerns are identified, the issue will be immediately corrected, and additional training will be initiated. The outcomes will be reviewed through the facility Quality Assurance Program at least quarterly. By what date the systemic changes for each deficiency will be completed: March 22, 2024	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected			

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	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. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct fire drills on each shift for 1 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on records review with the Administrator and the Maintenance Director on 03/07/24 at 10:00 a.m., no documentation was available to show a first, second, or third shift fire drill for the second quarter of 2023 were conducted. Based on interview at the time of record review, the Maintenance Director stated the aforementioned drills were not conducted due to there was no Maintenance Director during that time. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	K 0712 Fire Drills It is the practice of River Terrace Retirement Community to conduct fire drills once a shift per quarter. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were identified as being affected by the deficient practice. Maintenance staff were educated regarding conducting fire drills once a shift per quarter on 3-18-24. How other residents having the potential to 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 same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by the deficient	03/22/2024

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	155726	A. BUILDING 01 B. WING	03/07/2024

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			practice. A Life Safety binder has been created to record the monthly fire drills. Documentation of the drills will be kept in the Life Safety binder. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The monthly fire drill testing was reviewed by the administrator, maintenance director and maintenance assistant. An in-service was conducted with the maintenance department on the policy. A performance improvement tool has been developed to monitor required testing. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: A Quality Assurance tool has been developed and implemented that randomly audits. This tool will be completed by the Administrator and/or his/her designee weekly times three, then monthly times three and then quarterly times three. In the event any further concerns are identified, the issue will be immediately corrected, and additional training will be initiated. The outcomes will be reviewed	

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			through the facility Quality Assurance Program at least quarterly. By what date the systemic changes for each deficiency will be completed: March 22, 2024	
K 0918 SS=F Bldg. 01	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			

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	and readily available. EES electrical panels and circuits are marked, readily identifiable, 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)			
	Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 4 of 12 months and weekly inspection for 16 of 52 weeks. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Section 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and the Maintenance Director on 03/07/24 at 10:15 a.m., no documentation was available to show the generator set in service was exercised at least once monthly, for a minimum of 30 minutes between April and July of 2023. Also, the generator weekly inspection log showed no weekly inspections were conducted between April	K 0918	K0918 Electric Systems It is the practice of River Terrace Retirement Community to test the generator monthly. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were identified as being affected by the deficient practice. Maintenance staff were educated regarding monthly generator testing on 3-18-24. How other residents have 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 deficient practice. A Life Safety binder has been created to record the monthly generator test. Documentation of the test will be kept in the Life Safety binder. What measures will be put into	03/22/2024

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	and July of 2023. Based on an interview at the time of record review, the Maintenance Director stated the aforementioned load tests and weekly tests were not conducted due to no Maintenance Director during that time. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		place and what systemic changes will be made to ensure that the deficient practice does not recur: The monthly testing of the generator form was reviewed by the administrator, maintenance director and maintenance assistant. An in-service was conducted with the maintenance department on the policy on 3-18-24. a performance improvement tool has been developed to monitor required testing. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: A Quality Assurance tool has been developed and implemented that randomly audits. This tool will be completed by the administrator and or his/her designee weekly times three, then monthly times three and then quarterly times three. In the event any further concerns are identified, the issue will be immediately corrected, and additional training will be initiated. The outcomes will be reviewed through the facility Quality Assurance Program at least quarterly. By what date the systemic changes for each deficiency will	

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			be completed: March 22, 2024	