PRINTED: 03/27/2024 FORM APPROVED

ENTERS FO	R MEDICARE & MEDI	CAID SERVICES			OMI	B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155726	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY  COMPLETED  03/07/2024	
	PROVIDER OR SUPPLIE		400 CA	ADDRESS, CITY, STATE, ZIP COD AYLOR BLVD FTON, IN 46714	<u> </u>	
(X4) ID PREFIX TAG E 0000	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
Bldg	conducted by the I accordance with 4.  Survey Date: 03/0  Facility Number: 0.  Provider Number: AIM Number: 200  At this Emergency Terrace Health Ca compliance with E Requirements for Participating Prov. 483.73. The facility	07/24 003575 155726	E 0000	K 0000 By submitting the enclosed materials, we are not admittin truth or accuracy of any spec findings or allegations. We re the right to contest the finding allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The farequests that the plan of correction be considered our allegation of compliance effect March 22, 2024 for the survey completed March 7th.	iffic eserve gs or e acility	
E 0037 SS=F Bldg	403.748(d)(1), 44 441.184(d)(1), 48 483.73(d)(1), 484 485.68(d)(1), 48 486.360(d)(1), 48 EP Training Prog §403.748(d)(1), §			River Terrace Retirement Community would like to respectfully request a desk review/paper compliance of th plan of correction.  p="">	his	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

§483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)

> TITLE (X6) DATE

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE	SURVEY			
	OF CORRECTION	IDENTIFICATION NUMBER	l í	A. BUILDING		COMPLETED	
THE TENT	or conduction	155726	B. W			03/07	
		133720	<i>D.</i> 11			30,07	,
NAME OF P	PROVIDER OR SUPPLIER	R			ADDRESS, CITY, STATE, ZIP COD		
DI) (55 -	EDD 4 OF 1 'E 41 E' '	OADE OFNITED			YLOR BLVD		
KIVER T	ERRACE HEALTH	CARE CENTER		RLUFF	TON, IN 46714		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	IATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(1), §485.920(d)(1	1), §486.360(d)(1),					
	§491.12(d)(1).						
	*[For RNCHIs at §403.748, ASCs at §416.54,						
		.15, ICF/IIDs at §483.475,					
	_	2, "Organizations" under					
	-	at §486.360, RHC/FQHCs					
	at §491.12:]						
	. ,	ram. The [facility] must do					
	all of the following:						
		n emergency preparedness					
		edures to all new and					
	existing staff, individuals providing services under arrangement, and volunteers,						
	_						
		eir expected roles.					
	. ,	jency preparedness training					
	at least every 2 ye						
	preparedness trai	mentation of all emergency					
		staff knowledge of					
	emergency proce						
	• • •	ncy preparedness policies					
		re significantly updated, the					
	•	duct training on the					
	updated policies a						
	, pana.30 c	,					
	*[For Hospices at	§418.113(d):] (1) Training.					
	· ·	t do all of the following:					
	(i) Initial training ir	n emergency preparedness					
	policies and proce	edures to all new and					
	existing hospice e	employees, and individuals					
	providing services	s under arrangement,					
	consistent with the	eir expected roles.					
	(ii) Demonstrate s	staff knowledge of					
	emergency proce						
		gency preparedness training					
	at least every 2 years.						
	(iv) Periodically re	eview and rehearse its					
	emergency prepa	redness plan with hospice					
	employees (includ	ding nonemployee staff),					

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155726	l í	JILDING	NSTRUCTION	COMI	E SURVEY PLETED 7/2024
	OF PROVIDER OR SUPPLIE		-	400 CA	ADDRESS, CITY, STATE, ZIP CO YLOR BLVD FON, IN 46714	D	_
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION ULD BE PROPRIATE	(X5) COMPLETION
TAG	with special emph the procedures no and others.  (v) Maintain docu preparedness trai (vi) If the emerger and procedures are hospice must consupdated policies are procedures.  *[For PRTFs at §a program. The PR following: (i) Initial training in policies and procedures arrangeme consistent with the (ii) After initial training preparedness training training preparedness training training preparedness training training to procedures are procedures are procedures are procedures are procedures and procedures are procedures and procedures are procedures and procedures are procedures and procedures and procedures and procedures and procedures are procedures and proc	ncy preparedness policies re significantly updated, the duct training on the and  441.184(d):] (1) Training TF must do all of the  n emergency preparedness edures to all new and viduals providing services nt, and volunteers, eir expected roles. ning, provide emergency ning every 2 years. staff knowledge of dures. Immentation of all emergency ning. ncy preparedness policies re significantly updated, the act training on the updated edures.  60.84(d):] (1) The PACE to do all of the following: In emergency preparedness edures to all new and viduals providing on-site rangement, contractors, volunteers, consistent with ess. gency preparedness training		TAG			DATE

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	NT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155726	A. BUILI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 03/07/2024	
	PROVIDER OR SUPPLIEI		4	100 CAY	DDRESS, CITY, STATE, ZIP COD 'LOR BLVD ON, IN 46714		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  NCY MUST BE PRECEDED BY FULL  DUE OF DEFICIENCY DIFFORMATION	PR	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION	
TAG	(iii) Demonstrate emergency proce participants of wh whom to contact is (iv) Maintain docu. (v) If the emerge and procedures a PACE must condition policies and procedures	es at §483.73(d):] (1) . The LTC facility must do all n emergency preparedness edures to all new and viduals providing services nt, and volunteers, eir expected role. gency preparedness training umentation of all emergency ining. staff knowledge of dures.  485.68(d):](1) Training. The I of the following: raining in emergency icies and procedures to all staff, individuals providing rangement, and volunteers, eir expected roles. gency preparedness training		AG	DEFICIENCY		DATE

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	MENT OF DEFICIENCIES  AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155726		JILDING	NSTRUCTION	COM	e survey pleted 17/2024
	OF PROVIDER OR SUPPLIE		-	400 CA	ADDRESS, CITY, STATE, ZIP CO YLOR BLVD FON, IN 46714	D	_
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	CCTION ULD BE PROPRIATE	(X5) COMPLETION DATE
	workday. The trai instruction in the systems and sign equipment.  (v) If the emerge and procedures a CORF must cond policies and procedures and disaster auth existing staff, indictional under arrangeme consistent with the (ii) Provide emergency procedures and procedures to all individuals provid arrangement, and their expected rol	ning program must include ocation and use of alarm als and firefighting ency preparedness policies re significantly updated, the uct training on the updated edures.  85.625(d):] (1) Training H must do all of the emergency preparedness edures, including prompt inguishing of fires, here necessary, evacuation innel, and guests, fire operation with firefighting orities, to all new and viduals providing services int, and volunteers, eir expected roles. Hency preparedness training ears. Hency preparedness policies re significantly updated, the cottraining on the updated edures.  8485.920(d):] (1) Training. Provide initial training in redness policies and new and existing staff, ing services under I volunteers, consistent with					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155726	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/07/2024
	PROVIDER OR SUPPLIEF		400 C	ADDRESS, CITY, STATE, ZIP COD AYLOR BLVD FTON, IN 46714	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5)  COMPLETION  DATE
	emergency proce-CMHC must proviper paredness traingular training in emergency procedures to all training in emergency procedures to all new individuals providing and volunteers, controles; (ii) Provide estraining at least and documentation of a training; (iv) Demonemergency procedures to all new individuals providing and volunteers, controles; (ii) Provide estraining at least and documentation of a training; (iv) Demonemergency procedures all residents in the findings include:  Based on records reand the Maintenance a.m., no documentation to demonstrate knowless for review. Based of records review, the training was not control.	ning at least every 2 years.  view and interview, the facility mual training for the edness Program (EPP). The LTC of the following: (i) Initial ecy preparedness policies and ew and existing staff, ing services under arrangement, esistent with their expected mergency preparedness equally; (iii) Maintain ill emergency preparedness enstrate staff knowledge of eres in accordance with 42 CFR deficient practice could affect facility.  eview with the Administrator the Director on 03/07/24 at 10:49 etion of annual EEP training and	E 0037	E 0037 Emergency Prepare Training Program  It is the practice of River Tel Retirement Community to the employees upon hire and an on emergency preparednes.  What corrective action(s) with accomplished for those resident found to have been affected deficient practice:  No residents were identified being affected by the deficient practice. All staff will be edue by March 22, 2024  How other residents having potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken:  All residents have the potent be affected by the deficient practice. An emergency preparedness training guide been created to record the education and training of all and existing employees.  Documentation of annual aremployee orientation will be in that binder.  What measures will be put i	rrace ain all anually s.  If be dents If by the  as ent ucated  the ne be re  tial to  thas new and new kept

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DEPARTMENT CENTERS FOI	FORM APPROVED					
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING		ONSTRUCTION	OMB NO. 0938-039  (X3) DATE SURVEY  COMPLETED  03/07/2024			
	PROVIDER OR SUPPLIE		400 CA	ADDRESS, CITY, STATE, ZIP COD AYLOR BLVD TON, IN 46714		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION GEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)  place and what systematic change will be made to ensure that the deficient practice does recur:  The emergency preparedness was reviewed by the administration maintenance director, and maintenance assistant. An in-service was conducted with facility personnel on the policy performance improvement tool been developed to monitor the required training (new and exist employees).  How the corrective action will be monitored to ensure the deficie practice will not recur, i.e., what quality assurance program will put into place:  A Quality Assurance tool has been developed and implement that randomly audits. This toll be completed by the Administrand/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 issuance in the second of the concerns are identified, the issuance concerns are identified, the issuance concerns are identified, the issuance change of the concerns are identified.	plan ator,  all . A I has esting  be ent at I be inted will eator yy s	(X5) COMPLETION DATE
				will be immediately corrected, additional training will be initiated.  The outcomes will be reviewed.	ted.	

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quarterly.

through the facility Quality Assurance Program at least

By what date the systemic changes for each deficiency will

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	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155726	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION (	X3) DATE SURVEY COMPLETED 03/07/2024
	ROVIDER OR SUPPLIER		400 CA	ADDRESS, CITY, STATE, ZIP COD AYLOR BLVD TON, IN 46714	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE
14 0000				be completed:  March 22, 2024	
K 0000					
Bldg. 01	Licensure Survey w Department of Heal 483.90(a).  Survey Date: 03/07  Facility Number: 00 Provider Number: 1 AIM Number: 2003  At this LSC survey, Center was found in Requirements for Pomedicare/Medicaid Life Safety from Fin National Fire Protect LSC, Chapter 19, Et Occupancies and 41  This one story facility of the corridors and the resident rooms. 30 and had a census survey.  All areas where the access were sprinklemaintenance building.	203575 55726 695060 River Terrace Health Care of in compliance with articipation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, xisting Health Care	K 0000	K 0000 By submitting the enclosed materials, we are not admitting truth or accuracy of any specific findings or allegations. We reset the right to contest the findings allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The fact requests that the plan of correction be considered our allegation of compliance effection 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=""">	c erve or ility ve

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPLETE			ETED
		155726	B. W	NG	<del></del>	03/07/	/2024
				_			
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
D., (ED. T.		OADE OFNITED			YLOR BLVD		
RIVER	ERRACE HEALTH	CARE CENTER		BLUFF	TON, IN 46714		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	sprinklered.						
	•						
	Quality Review con	npleted on 03/08/24					
	` ,	•					
K 0291	NFPA 101						
SS=F	Emergency Lightin	ng					
Bldg. 01	Emergency Lightin	<del>-</del>					
		g of at least 1-1/2-hour					
		ed automatically in					
	accordance with 7						
	18.2.9.1, 19.2.9.1						
	Based on records review, observation, and K 0291 K 291 Emergency Lighting			03/22/2024			
		ty failed to ensure 7 of 7	11.0				0072272021
		ts were properly tested.			It is the practice of River Terra	ice	
		quires functional testing shall			Retirement Community to test		
		hly, with a minimum of 3 weeks			battery backup lights monthly.		
		5 weeks between tests, for not					
		s. Functional testing shall be			What corrective action(s) will be	oe	
		for a minimum of 1 1/2 hours			accomplished for those reside		
	-	ghting system is battery			found to have been affected b		
		ecords of visual inspections			deficient practice:	•	
	and tests shall be ke	ept by the owner for			·		
	inspection by the au	thority having jurisdiction.			No residents were identified a	S	
	This deficient pract	ice affects all residents.			being affected by the deficient		
	_				practice. Maintenance staff w		
	Findings include:				educated regarding monthly		
					testing of batter backup		
	Based on observation	on with the Administrator and			emergency light on 3-18-24,	ļ	
	the Maintenance Di	rector on 03/07/24 between					
	11:00 a.m. and 12:0	00 p.m., in the healthcare wing			How other residents having th	е	
	there were seven ba	attery-operated emergency			potential to be affected by the		
	lights in the halls. E	Based on records review at			same deficient practice will be		
		y testing for the battery			identified and what corrective	ļ	
	·	y lights were not conducted			action(s) will taken:	ļ	
		July of 2023. Also, there was				ļ	
	no documentation f	or the 90-minute annual light			All residents have the potentia	ıl to	
		terview, the Maintenance			be affected by the deficient	ļ	
		the testing for the battery			practice. A Life Safety binder	has	
		not conducted due to there			been created to record the	ļ	
		nce Director during that time.			monthly battery backup test of	the	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 01 COMPLETED			· ′		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155726		UILDING ⁄ING	01	03/07/2024	
		100120	. W			33/3/1/23Z <del>T</del>	
NAME OF P	ROVIDER OR SUPPLIEF	1			ADDRESS, CITY, STATE, ZIP COD YLOR BLVD		
RIVER TI	ERRACE HEALTH	CARE CENTER			TON, IN 46714		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)	DATE	_
	-	viewed with the Administrator irector during the exit			emergency lights. Documenta of the test will be kept in the L Safety binder.		
					What measures will be put into	0	
	3.1-19(b)				place and what systemic chan		
					will be made to ensure that the		
					deficient practice does not rec	eur:	
					The monthly testing of the bat	terv	
					backup of the emergency light	•	
					form was reviewed by the		
					administrator, maintenance		
					director and maintenance		
					assistant. An in-services was		
					conducted with the maintenan	ice	
					department on the policy on 3-18-24. A performance		
					improvement tool has been		
					developed to monitor required		
					testing.		
					How the corrective action(s) w	<i>r</i> ill	
					monitored to ensure the defici		
					practice will not recur, i.e., who	at	
					quality assurance program wil	l be	
					put into place:		
					A Quality Assurance tool has		
					been developed and impleme	nted	
					that randomly audits. This too	ol	
					will be completed by the		
					Administrator and/or designee		
					weekly times three, then mont times three and then quarterly	•	
					times three. In the event any		
					further concerns are identified	, the	
					issue will be immediately	, ·	
					corrected, and additional train	ing	
					will be initiated. The outcome	-	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155726	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction (	COMPLETED 03/07/2024
	PROVIDER OR SUPPLIEF		400 CA	ADDRESS, CITY, STATE, ZIP COD AYLOR BLVD TON, IN 46714	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
				will be reviewed through the fact 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	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testin Water-based Fire Records of system inspection and tes secure location ar a) Date sprinkler b) Who provided c) Water system Provide in REMAR coverage for any	supply source  RKS information on non-required or partial			
	failed to maintain 1 accordance with LS automatic sprinkler and maintained in a Standard for the Ins	-	K 0353	K 0353 Sprinkler System  It is the practice of River Terrac Retirement Community to week test the dry pipe sprinkler system's gauges and valves.	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155726	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 03/07/2024
	PROVIDER OR SUPPLIER		400 CA	ADDRESS, CITY, STATE, ZIP COD YLOR BLVD TON, IN 46714	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	indicates the require testing. NFPA 25, 5 pipe sprinkler syste and gauges on dry s	, 2011 edition, Table 5.1.1.2 ed frequency of inspection and .2.4.1 states gauges on wet ms shall be inspected monthly ystems (5.2.4.2) shall be ensure normal water or air		What corrective action(s) will accomplished for those reside found to have been affected be deficient practice:	ents
	states valves should valves secured lock shall be permitted to	be inspected weekly or sor supervised (13.3.2.1.1) be inspected monthly. This bull affect all occupants.		No residents were identified a being affected by the deficient practice. Maintenance staff weducated regarding weekly te of the dry pipe sprinkler system gauges and valves on 3-18-24	t rere sting m's
	Director on 03/07/2 weekly inspection of system's gauges and April to July of 202 time of record review	view with the Maintenance 4 at 10:13 a.m., there was no if the dry pipe sprinkler I valves for the months of 3. During an interview at the w, the Maintenance Director in of gauges and valves were		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 be affected by the deficient	e ·
	not conducted due t Director during that This finding was re	o there being no Maintenance		practice. A Life Safety binder been created to record the we dry pipe sprinkler system's gauges and valves. Documentation of the test will kept in the Life Safety binder.	eekly
	3.1-19(b)			What measures will be put int place and what systemic char will be made to ensure that the deficient practice does not recommend.	nges e cur:
				The weekly testing of the dry 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155726	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  03/07/2024		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 400 CAYLOR BLVD				
RIVER T	ERRACE HEALTH	CARE CENTER		TON, IN 46714			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  DEFINITION OF LIGHTERING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
TAG	REGULATORY OF	LISC IDENTIFYING INFORMATION	TAG	department on the policy on 3-18-24. A performance improvement tool has been developed to monitor required testing.  How the corrective action(s) we monitored to ensure the defici practice will not recur, i.e., who quality assurance program will put into place:  A Quality of Assurance tool has been developed and implement that randomly audits. This too will be completed by the Administrator and/or his/her designee monthly times three, then quarterly times three, then quarterly times three, the semi-annually. In the event and further concerns are identified issue will be immediately corrected, and additional train will be initiated. The outcome will be reviewed through the factorial quarterly.  By what date the systemic changes for each deficiency we be completed:	vill be ent at l be l b		
K 0712 SS=F Bldg. 01		the transmission of a fire		March 22, 2024			

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conditions. Fire drills are held at expected

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	r í	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
		IDENTIFICATION NUMBER		A. BUILDING <u>01</u>		COMPLETED		
		155726	B. W	B. WING 03/07/2024				
NAME OF PROVIDER OR SUPPLIER RIVER TERRACE HEALTH CARE CENTER			-	STREET ADDRESS, CITY, STATE, ZIP COD 400 CAYLOR BLVD BLUFFTON, IN 46714				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDEDIC DI ANI DE CORRECTIONI		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF.	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
TAG	and unexpected ti conditions, at leas The staff is familia aware that drills aroutine. Where dr 9:00 PM and 6:00 announcement ma audible alarms. 19.7.1.4 through 1 Based on record rev failed to conduct fir quarters. LSC 19.7. conducted quarterly facility personnel (r engineers, and admisignals and emerger varied conditions. Tall staff and residen Findings include:  Based on records reand the Maintenance a.m., no documenta first, second, or thir quarter of 2023 wer interview at the tim Maintenance Direct drills were not cond Maintenance Direct This finding was reviewed.	mes under varying at quarterly on each shift. In with procedures and is re part of established rills are conducted between AM, a coded and be used instead of 19.7.1.7  Wiew and interview, the facility re drills on each shift for 1 of 4 1.6 states drills shall be an on each shift to familiarize nurses, interns, maintenance inistrative staff) with the next action required under this deficient practice affects ts.  Eview with the Administrator re Director on 03/07/24 at 10:00 tion was available to show a d shift fire drill for the second re conducted. Based on e of record review, the constated the aforementioned flucted due to there was no	K 0		K 0712 Fire Drills  It is the practice of River Terra Retirement Community to confire drills once a shift per quare.  What corrective action(s) will accomplished for those reside found to have been affected be deficient practice:  No residents were identified a being affected by the deficient practice. Maintenance staff we ducated regarding conductin drills once a shift per quarter of 3-18-24.  How other residents having the potential to affected by the said deficient practice will be identified and what corrective action(s) will be taken:  All residents have the potential be affected by the same deficient practice will be identified and corrective action(s) will be taken.  All residents have the potential be affected by the deficient practice will be identified and corrective action(s) will be taken.	ace duct ter.  be ents y the  s t ere g fire on  e me ified will  al to ient what en:	03/22/2024	

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES	OMB NO. 0938-039					
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUM		A. BUILDING <u>01</u>			COMPL	LETED	
	155726		B. W	ING		03/07	/2024	
				STREET .	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	₹			YLOR BLVD			
RIVER T	ERRACE HEALTH	CARE CENTER			TON, IN 46714			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					practice. A Life Safety binder	has		
					been created to record the			
					monthly fire drills. Documenta			
					of the drills will be kept in the I	₋ife		
					Safety binder.			
					What measures will be put into	)		
					place and what systemic chan			
					will be made to ensure that the	•		
					deficient practice does not rec			
					The monthly fire drill testing wa	20		
					reviewed by the administrator,			
					maintenance director and			
					maintenance assistant. An			
					in-service was conducted with	the		
					maintenance department on the			
					policy. A performance	10		
					improvement tool has been			
					developed to monitor required			
					testing.			
					How the corrective action(s) w	rill be		
					monitored to ensure the deficie			
					practice will not recur, i.e., who			
					quality assurance program will			
					put into place:			
					A Quality Assurance tool has			
					been developed and implemen	nted		
					that randomly audits. This tool			
					be completed by the Administr			
					and/or his/her designee weekl			
					times three, then monthly time	-		
					three and then quarterly times			
					three. In the event any further			
					concerns are identified, the iss			
					will be immediately corrected,			

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additional training will be initiated. The outcomes will be reviewed

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155726		r ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/07/2024	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
RIVER T	ERRACE HEALTH	CARE CENTER			YLOR BLVD FON, IN 46714		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL	PRE		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	T/	A.G	through the facility Quality Assurance Program at least quarterly.  By what date the systemic changes for each deficiency w be completed:  March 22, 2024	vill	DATE
					War of 22, 202 1		
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro- annually confirm the safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under to year in 20-40 day once every 36 mo Scheduled test un a complete simula automatic or manu- loads, and are cor personnel. Mainte energy power sou accordance with N circuit breakers ar program for period components is est manufacturer requ	other alternate power ated equipment is capable be within 10 seconds. If the in is not met during the becess shall be provided to inis capability for the life branches. Maintenance generator and transfer branches in accordance with it inspected weekly, and 30 minutes 12 times a intervals, and exercised inthis for 4 continuous hours. indeed to a condition include					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155726		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/07/2024				
NAME OF PROVIDER OR SUPPLIER RIVER TERRACE HEALTH CARE CENTER			400 CA	STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE			
	and circuits are m and separate from Minimizing the pose emergency power consideration for r 6.4.4, 6.5.4, 6.6.4 NFPA 111, 700.10 Based on record rev failed to maintain a monthly generator I and weekly inspectic 6.4.4.1.1.4(a) of 20 testing of the general electrical system to 110, the Standard for Powers Systems, Cl requires diesel gene exercised at least or 30 minutes. Section Power Supply Systems, Cl requires diesel gene exercised at least or 30 minutes. Section Power Supply Systems, Cl requires diesel gene exercised at least or 30 minutes. Section Power Supply Systems, Cl requires diesel gene exercised at least or 30 minutes. Section Power Supply Systems, Cl requires diesel gene exercised at least or 30 minutes. Section Power Supply Systems, Cl requires diesel gene exercised at least or 30 minutes. Section Power Supply Systems, Cl requires diesel gene exercised at least or 30 minutes. Section Power Supply Systems, Cl requires diesel gene exercised at least or 30 minutes. Section Power Supply Systems, Cl requires diesel gene exercised at least or 30 minutes. Section Power Supply Systems, Cl requires diesel gene exercised at least or 30 minutes. Section Power Supply Systems, Cl requires diesel gene exercised at least or 30 minutes. Section Power Supply Systems, Cl requires diesel gene exercised at least or 30 minutes. Section Power Supply Systems, Cl requires diesel gene exercised at least or 30 minutes. Section Power Supply Systems, Cl requires diesel gene exercised at least or 30 minutes. Section Power Supply Systems, Cl requires diesel gene exercised at least or 30 minutes. Section Power Supply Systems, Cl requires diesel gene exercised at least or 30 minutes. Section Power Supply Systems, Cl requires diesel gene exercised at least or 30 minutes. Section Power Supply Systems, Cl requires diesel gene exercised at least or 30 minutes. Section Power Supply Systems, Cl requires diesel gene exercised at least or 30 minutes. Section Power Supply Systems, Cl requires diesel gene exercised at least or 30 minutes. S	(NFPA 99), NFPA 110, 0 (NFPA 70) riew and interview, the facility complete written record of oad testing for 4 of 12 months on for 16 of 52 weeks. Chapter 12 NFPA 99 requires monthly ator serving the emergency be in accordance with NFPA or Emergency and Standby napter 8. NFPA 110 8.4.2 rator sets in service to be accompany to the emergency em (EPSS) including all nents, shall be inspected and monthly. Chapter 6.4.4.2 of written record of inspection, ising period, and repairs for the alarly maintained and available	K 0918	K0918 Electric Systems  It is the practice of River Terr. Retirement Community to test generator monthly.  What corrective action(s) will accomplished for those reside found to have been affected by deficient practice:  No residents were identified a being affected by the deficient practice. Maintenance staff we ducated 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 be affected by the deficient practice. A Life Safety binder been created to record the monthly generator test.  Documentation of the test will kept in the Life Safety binder.	t the be ents by the as as t were al to has			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155726		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 03/07/2024				
NAME OF PROVIDER OR SUPPLIER RIVER TERRACE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 400 CAYLOR BLVD BLUFFTON, IN 46714					
RIVER TO (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OR and July of 2023. B of record review, th the aforementioned were not conducted Director during that	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION ased on an interview at the time e Maintenance Director stated load tests and weekly tests due to no Maintenance		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  place and what systemic char will be made to ensure that the deficient practice does not red. The monthly testing of the generator form was reviewed the administrator, maintenance assistant. An in-service was conducted with the maintenance assistant on the policy on 3-18-24. a performance improvement tool has been developed to monitor required testing.  How the corrective action(s) we monitored to ensure the defice practice will not recur, i.e., who quality assurance program with put into place:  A Quality Assurance tool has been developed and implement that randomly audits. This too will be completed by the administrator and or his/her designee weekly times three, monthly times three and then quarterly times three and then quarterly times three. In the easy further concerns are iden the issue will be immediately corrected, and additional train will be initiated. The outcome will be reviewed through the form Quality Assurance Program and least quarterly.  By what date the systemic	nges e cur: by ee nce d vill be ient at ll be nted bl then event tified, ning es acility t			
			changes for each deficiency v	vill				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	LDING	01	COMPLETED		
		155726	B. WING	B. WING			03/07/2024	
NAME OF PROVIDER OR SUPPLIER RIVER TERRACE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 400 CAYLOR BLVD BLUFFTON, IN 46714				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DAT			
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PF	REFIX				
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG				
					be completed:			
					March 22, 2024			

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