STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155328	B. WI	NG		03/10/	2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L			DEHNE CAMP RD		
PARK TE	RRACE VILLAGE			EVANSVILLE, IN 47712			
(X4) ID		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' DEFICIENCY)	ΓE	COMPLETION
TAG F 0000	REGULATORY OR	LISC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
F 0000							
Bldg. 00							
Diag. 00	This visit was for a	Recertification and State	F 00	000	The creation and submission o	of	
	Licensure Survey.		1 0000		this Plan of Correction does not		
	,				constitute an admission by this		
	Survey dates: March	h 3, 4, 5, 6, 7, and 10, 2025			provider of any conclusion set		
					in the statement of deficiencies	s, or	
	Facility number: 00				of any violation of regulation. T		
	Provider number: 1:				provider respectfully requests		
	AIM number: 1002	67620			the 2567 Plan of Correction be		
	C D 1 T				considered the Letter of Credit		
	Census Bed Type: SNF/NF: 60				Allegation and requests a Pos		
	Total: 60				Certification Desk Review in lie	eu ot	
	10141. 00				the Post Survey Revisit.		
	Census Payor Type:	:					
	Medicare: 3						
	Medicaid: 48						
	Other: 9						
	Total: 60						
	These deficiencies t	reflect State Findings cited in					
	accordance with 410	_					
	Quality review com	pleted on March 18, 2025.					
F 0550	483.10(a)(1)(2)(b)	(1)(2)					
SS=D	Resident Rights/E						
Bldg. 00	· ·	•					
		on, interview, and record	F 05	550	It is the policy of the facility to		04/09/2025
	•	failed to ensure a resident was			treat each resident with respec	ct	
		during a meal observation for			and dignity and care for each		
		iewed for activities of daily			resident in the manner and in	an	
		staff assistance to eat.			environment that promotes	_	
	(Resident 3)				maintenance or enhancement of		
	Finding includes:				his or her quality of life,		
	r maing menuces:				recognizing each resident's individuality. It is the policy of	the	
	During an interview	on 3/4/25 at 10:04 A.M., a			facility to protect and promote		
			1		l acinty to protoct and promote		

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

(X6) DATE

TITLE

Claudia Schmitt Administrator 03/28/2025

Any defiency statement 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					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING 00 COMPLETED		
		155328	B. W	'ING		03/10/2025
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD	1
NAME OF I	PROVIDER OR SUPPLIER	8			OEHNE CAMP RD	
PARK TE	ERRACE VILLAGE			EVANSVILLE, IN 47712		
(X4) ID	SUMMARV	STATEMENT OF DEFICIENCIE		ID		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	` `	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
		icated Resident 3 is not able to			rights of the residents.	21112
		aff not always willing to assist			•What corrective action(s) w	ill
	her with eating.	ar net arways wining to assist			be accomplished for those	""
					residents found to have been	n
	On 3/5/25 at 10:20	A.M., Resident 3's clinical			affected by the deficient	••
		d. Resident 3's diagnoses			practice;	
		not limited to, hypertensive			-Resident #3 is being treated	with
		ongestive heart failure (CHF).			respect and dignity. Resident	
		gnificant Change Minimum			is being assisted with eating f	
	_	sessment, dated 2/15/25,			meals. Resident #3 profile wa	
	` ′	3 was severely cognitively			updated.	
	impaired and was d	ependant on staff (staff do all			·	
	of the work) for eating, toileting, showering, and				•How other residents having	
	transfers, and receiv	ved oxygen therapy.			the potential to be affected by	ру
					the same deficient practice v	will
	Current care plans i	ncluded, but were not limited			be identified and what	
	to:				corrective action(s) will be	
	_	ssistance with ADLs (activities			taken;	
		uding bed mobility, transfers,			-All residents have the potenti	al to
		related to: weakness,			be affected by the alleged def	icient
		incontinence, impaired			practice.	
	cognition, Start date	e 6/22/22			-All nursing staff will be educa	
		0/5/05 40.04.53.5			by DNS/designee on identification	
	_	ion on 3/5/25 at 12:24 P.M.,			of residents requiring assist w	
		l lunch trays had been passed.			meals, and ensuring that whe	
		ray was sitting on her bedside			meals are served, a staff men	
		at of her reach, and staff were at 3. At 12:51 P.M., CNA 9			begins assisting resident with	
	_	l to CNA 5, who was removing			eating at time of serving.	
		Resident 3's room, and asked			•What measures will be put	
	_	3 still needed to be fed. CNA 5			into place and what systemi	_
		ot, and entered Resident 3's			changes will be made to	
	room to assist with				ensure that the deficient	
	100m to assist with	recard ner.			practice does not recur;	
	During an interview	on 3/10/25 at 11:26 A.M., The			-CNA #9 and CNA #5 were	
	_	eated the facility did not have a			educated on assisting residen	ıts
		ed to dignity but the facility's			with meals timely	
		all residents with dignity and			-Daily rounds will be complete	ed
	respect.	·-B,			by meal manager/designee to	
					ensure all residents who requ	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155328	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/10/2025
	PROVIDER OR SUPPLIER		25 S B	ADDRESS, CITY, STATE, ZIP COD OEHNE CAMP RD SVILLE, IN 47712	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	3.1-3(t)			assist with meals are being assisted timely.	
				•How the corrective action(s will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place -The DNS/designee will be responsible for the completio the Resident Rights QAPI To weekly x4 weeks, monthly x6 then quarterly until continued compliance is maintained for consecutive quarters. The reof these audits will be review the QAPI committee oversee the ED. If company threshold not achieved, an action plant be developed. Deficiency in t practice will result in disciplin action up to and including termination of responsible employee.	the put n of ol and 2 esults ed by n by is will his
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Adn	nin Meds-Clinically Approp			
	review, the facility were self administer assessed for capabil medications for 1 or medications in their Finding includes: On 3/4/25 at 10:04	on, interview, and record failed to ensure residents that ring medications were ity to self administer f 1 residents observed with room. (Resident 8) A.M., a white pill and a red pill medication cup on Resident 8's	F 0554	It is the policy of the facility allow residents to self-administer medications when deemed safe and appropriate by the IDT team •What corrective action(s) when the accomplished for those residents found to have been affected by the deficient practice; -Resident #8 was assessed as	i. vill

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155328	B. W	ING		03/10/	2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	L			DEHNE CAMP RD		
PARK TF	RRACE VILLAGE		EVANSVILLE, IN 47712				
			_		_, <u>-</u>		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION	+	TAG			DATE
	bedside table.				reviewed for self-administration	n.	
	On 2/5/25 at 12:25	D.M. Davidant Sla alimical			medications as well due to		
		P.M., Resident 8's clinical d. Diagnoses included, but			resident desire to eliminate the	•	
		type 2 diabetes mellitus and			number of medications. Resid		
	major depressive di					ent	
	major depressive di	soruci.			is not self-administering medications at this time.		
	The most recent Sic	gnificant Change Minimum			•How other residents having		
	_	sessment, dated 1/16/25,			the potential to be affected b		
	· ·	8 was cognitively intact, was			the same deficient practice v	-	
		for rolling left to right,			be identified and what	****	
	_	ng, and received antianxiety			corrective action(s) will be		
	medication, antidep	-			taken;		
	anticoagulants, diur				-All residents have the potent	ial to	
	_	cations during the seven day			be affected by the alleged def		
	look back period (1.				practices.		
	1	,			-All residents will be reviewed	to	
	The clinical record	lacked an assessment, order,			determine if they want or qual		
		d to the resident's ability to			for the need to self-administer	-	
	self administer med	ications.			medications.		
					-Nurses and QMAs will be		
	On 3/6/25 at 1:19 P	.M., Qualified Medication Aide			educated that only residents v	vith	
	(QMA) 14 indicated	d there were no residents who			orders to self-administer		
		f administer their own oral	medications can have medications				
	medications.				left at bedside.		
					•What measures will be put		
		.M., the Administrator indicated			into place and what systemic	C	
		not have a self administration			changes will be made to		
	of medication asses	sment or order.			ensure that the deficient		
	0.0/10/07				practice does not recur;		
		A.M., the Administrator			-Daily rounds will be complete		
	•	Self Administration of			daily by DNS/designee to ens		
		dated 11/2015, that indicated			no medications are left at bed	side	
		ns of the resident's ability to			unless resident has order for		
		lications must be made to			self-administration of medicati	on	
		effective procedures are			order.		
	followed".				•How the corrective action(s	•	
	2.1.11(a)				will be monitored to ensure t	ine	
	3.1-11(a)				deficient practice will not		
			1		recur, i.e., what quality		

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	Γ OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155328	ľ	ILDING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/10/2025	
	PROVIDER OR SUPPLIEI	₹		25 S B	ADDRESS, CITY, STATE, ZIP COD OEHNE CAMP RD SVILLE, IN 47712		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F 0695 SS=D Bldg. 00	483.25(i)	neostomy Care and		TAG	assurance program will be p into place -The DNS/designee will be responsible for the completion the self-administration of medication QAPI Tool weekly weeks, monthly x6 and then quarterly until continued compliance is maintained for consecutive quarters. The resof these audits will be reviewed the QAPI committee overseer the ED. If company threshold not achieved, an action plan who be developed. Deficiency in the practice will result in disciplinate action up to and including termination of responsible employee.	of x4 2 sults d by by is vill	DAIL
Blug. 00	Based on observati review, the facility services were provi standards for 3 of 3 respiratory care. Re at a flow rate that v	on, interview, and record failed to ensure respiratory ded according to professional residents reviewed for esidents were receiving oxygen vas not consistent with the esident 8, Resident 3, Resident	F 06	95	It is the policy of the facility provide respiratory care consistent with professional standards of practice, the comprehensive person-centered care plan, a per the residents' goals and preferences. •What corrective action(s) whe accomplished for those	ınd	04/09/2025

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oxygen.

1. On 3/4/25 at 10:10 A.M., Resident 8 was

observed lying in bed receiving 4 liters (L) of

indicated she was supposed to receive 3 L of

oxygen via nasal cannula. At that time, Resident $8\,$

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practice;

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residents found to have been

-Resident #8, resident #3 and

therapy per physician orders. ·How other residents having

resident #47 are receiving oxygen

affected by the deficient

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE	(X3) DATE SURVEY	
	LETED	
)/2025	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 25 S DOELINE CAMP DD		
25 S BOEHNE CAMP RD		
PARK TERRACE VILLAGE EVANSVILLE, IN 47712		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE	
On 3/5/25 at 12:35 P.M., Resident 8 was observed the potential to be affected by		
lying in bed receiving 4 L of oxygen via nasal the same deficient practice will		
cannula. be identified and what		
corrective action(s) will be		
On 3/6/25 at 1:18 P.M., Resident 8 was observed taken;		
lying in bed receiving 4 L of oxygen via nasal -All residents who wear oxygen		
cannula. have potential to be affected by		
the alleged deficient practice.		
On 3/5/25 at 12:25 P.M., Resident 8's clinical -All residents with an order for		
record was reviewed. Diagnoses included, but oxygen will be audited to ensure		
were not limited to, Chronic Obstructive they are using the correct liter of		
Pulmonary Disease (COPD). oxygen per physician order.		
-All nurses will be educated on		
The most recent Significant Change Minimum checking and ensuring residents		
Data Set (MDS) Assessment, dated 1/16/25, who wear oxygen are on the		
indicated Resident 8 was cognitively intact, was correct liter flow rate per physician		
dependent on staff to roll left and right, toileting,		
and bathing, and was receiving oxygen therapy. -QMA#14 received 1 on 1		
education regarding looking at		
Current physician orders included, but were not physician orders for oxygen flow		
limited to: Overse at 2 liters per posel cannot every shift.		
Oxygen at 2 liters per nasal cannula every shift, are needed.		
dated 1/10/25 •What measures will be put		
A current risk for impaired gas exchange care plan, into place and what systemic changes will be made to		
A current risk for impaired gas exchange care plan, revised 1/20/25, included an intervention of ensure that the deficient		
oxygen at 2 L per nasal cannula. practice does not recur;		
-Daily rounds will be completed		
On 3/6/25 at 1:20 P.M., Qualified Medication Aide by the DNS/designee to ensure		
(QMA) 14 indicated that Resident 8 was the residents who wear oxygen		
supposed to be on 2 to 3 liters of oxygen.2. are using the appropriate liter flow		
During an observation on 3/4/25 at 1:40 P.M., per physician order.		
Resident 3 was observed laying in bed. Her nasal •How the corrective action(s)		
cannula was not in her nose and the tubing was will be monitored to ensure the		
hanging on one ear. Resident 3's oxygen deficient practice will not		
concentrator was on 1 liter. recur, i.e., what quality		
assurance program will be put		
On 3/5/25 at 10:20 A.M., Resident 3's clinical into place		
record was reviewed. Resident 3's diagnoses -The DNS/designee will be		
included, but were not limited to, hypertensive responsible for the completion of		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			ETED
		155328	B. W	B. WING			2025
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
DADIC TE					DEHNE CAMP RD		
PARK IE	ERRACE VILLAGE			EVANS	VILLE, IN 47712		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CODDECTION		(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'	rc	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	I C	DATE
	heart disease and co	ongestive heart failure (CHF).			the respiratory care QAPI Too		
		,			weekly x4 weeks, monthly x6		
	The most recent Sig	gnificant Change Minimum			then quarterly until continued		
	_	sessment, dated 2/15/25,			compliance is maintained for 2)	
		3 was severely cognitively			consecutive quarters. The res		
		ependent on staff (staff do all			of these audits will be reviewe		
	_	ing, toileting, showering, and			the QAPI committee overseen	-	
		ved oxygen therapy.			the ED. If company threshold i	-	
	,	15.			not achieved, an action plan w		
	Current physician of	orders included, but were not			be developed. Deficiency in th		
	limited to:	,			practice will result in disciplina		
		er nasal cannula every shift,			action up to and including		
	start date 4/10/23	,			termination of responsible		
					employee.		
	The current care pla	an included, but was not			omployee.		
	limited to:						
		ial for impaired gas exchange					
	_	lizes supplemental O2 (oxygen),					
	Start date 1/17/24	meet suppremental of (engles),					
	Administer oxygen	as ordered - 2 liters per nasal					
	cannula, Start date	-					
	3 During an observ	vation on 3/4/25 at 2:24 P.M.,					
	_	en concentrator was on four					
		ndicated she should be					
	receiving 2 liters of						
	1300171118 2 111013 01						
	On 3/6/25 at 9:09 A	A.M., Resident 47's clinical					
		d. Resident 47's diagnoses					
		not limited to, chronic					
		ary disease (COPD).					
	oosa acave paimon	ary disease (COLD).					
	The most recent Ou	arterly Minimum Data Set					
	,	, dated 2/13/25, indicated					
		endent on staff (staff do all of					
	_	endent on starr (starr do an or ers, and received oxygen					
		ers, and received oxygen					
	therapy.						
	C	ndana in abadad bass					
	Current physician o	orders included, but were not					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 155328 B. WING		(X3) DATE SURVEY COMPLETED 03/10/2025		
	ROVIDER OR SUPPLIER		25 S B	ADDRESS, CITY, STATE, ZIP COD OEHNE CAMP RD SVILLE, IN 47712	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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
	limited to: Oxygen at 2 liters p start date 1/8/25	er nasal cannula every shift,			
	limited to:	in included, but was not ial for impaired gas exchange tart date 5/10/24			
	Administer oxygen as ordered - 2 liters per nasal cannula, Start date 5/10/24				
		on 3/7/25 at 8:48 stical Nurse (LPN) 10 indicated be receiving 2 liters of oxygen.			
	provided a current (11/2015, that indica	O.A.M., the Administrator Daygen Therapy policy, dated ted "The nurse will coordinate services as ordered by the ".			
	3.1-47(a)(6)				
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs				
	interview, the facilistorage of and label medication carts and Loose pills, food, an observed in the medication Cart, B Medication Cart, B Findings include:	on, record review, and ty failed to ensure proper ing of medications for 3 of 5 d 1 of 2 wound treatment carts. and unlabeled medications were dication and treatment cart t Cart for B Hall, A Hall Hall Medication Cart, C Hall	F 0761	It is the policy of the facility label and store drugs and biologicals in accordance wi currently accepted profession principles, and include the appropriate accessory and cautionary instructions, and expiration date when applicable. •What corrective action(s) wis be accomplished for those residents found to have been	the
	1. On 5/4/25 at 10:4	9 A.M., the Treatment Cart for		affected by the deficient	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155328	(X2) MULTIPLE (A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/10/2025
NAME OF F	PROVIDER OR SUPPLIEF	3		TADDRESS, CITY, STATE, ZIP COD BOEHNE CAMP RD	-
PARK TE	RRACE VILLAGE		EVAN	SVILLE, IN 47712	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	ION (X5)
TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	OPRIATE COMPLETION DATE
		erved with the following:		practice;	
		-		-Resident #28's and Resi	dent
		mer(cleaner) without label or		#19's medications are bei	ng
	resident name			stored appropriately.	
		third drawer in the third		-The identified bottle of pe	
	drawer			cleaner, soda, toe nail clip	•
		ppers no resident name or		chewing gum were remov	ed from
	storage bag			the cart.	aranga
	2 On 3/4/25 at 11:0	00 A.M., the B Hall Medication		-The identified round pill, of pill, acetaminophen, antibi	_
		to have an open package of		pills, and stool softener pil	
		out identification of ownership.		destroyed.	Were
				•How other residents hav	vina
	3. On 3/4/25 at 11:1	15 A.M., the A Hall Medication		the potential to be affect	- 1
	Cart was observed			the same deficient practi	-
		S		be identified and what	
	1 small round pill w	vith the number 11		corrective action(s) will be	oe l
	1 small round orang	ge pill with the letter F and the		taken;	
	number 50			-All residents have the po	tential to
		nophen (pain medication) 500		be affected by this alleged	i
	milligrams (Mg) wi	ithout label or open date.		deficient practice.	
				-All nurses and QMAs will	
		26 A.M., the C Hall Medication		educated on medication s	torage
		with 2 loose Cephalothin		and labeling.	
	(Antibiotic) pills in	a drawer.		-QMA #14 will receive 1 o	
	5 On 2/6/25 at 7.10	O A M. dywing a madiantian		education regarding medic	cation
		9 A.M., during a medication , Qualified Medication Aide		storage and labelingAll medication carts, treat	tmant
	_	erved dropping a pill on the		carts and medication roon	
		ledication Cart and placed into		audited to ensure medicat	
	-	t was later given to the		being stored appropriately	
	-	observed passing medications		•What measures will be p	
		refused a stool softener pill		into place and what syste	
		in a cup and left it unlabeled in		changes will be made to	
	a medication drawe	•		ensure that the deficient	
				practice does not recur;	
	During an interview	v on 3/4/25 at 10:55 A.M., the		-DNS/designee will comp	lete
	Assistant Director of	of Nursing (ADON) indicated if		daily audits of medication	and
		there should be a label. ADON		treatment carts to ensure	
	also indicated there	should be no food or nail		appropriate storage and la	abels are

FBXD11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155328		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 03/10/2025			
	PROVIDER OR SUPPLIE		25 S	EET ADDRESS, CITY, STATE, ZIP COD S BOEHNE CAMP RD ANSVILLE, IN 47712	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION DATE
	nail clippers should labeled. During an interview Director of Nursing QMA drops medication it is to a drawer unlabeled labeled with the na cup locked drawer. On 3/10/25 at 11:0 provided a current and Expiration Polindicated "food is storage areas where storedfacility should medications when	0 A.M., the Administrator policy "Medication Storage icy dated 11/24. The policy s not to be stored in general		in place. *How the corrective action(swill be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place -The DNS/designee will be responsible for the completion the medication storage QAPI weekly x4 weeks, monthly x6 then quarterly until continued compliance is maintained for consecutive quarters. The resof these audits will be review the QAPI committee oversee the ED. If company threshold not achieved, an action plan be developed. Deficiency in the practice will result in disciplinaction up to and including termination of responsible employee.	the put n of Tool and 2 esults ed by n by is will his
F 0812 SS=E Bldg. 00	Based on observati review, the facility produce food under related to food iten properly and sanita dietary areas observa- Findings include:	alk through on 3/4/25 at 9:03	F 0812	It is the policy of the facility store, prepare, distribute an serve food in accordance we professional standards for service safety. •What corrective action(s) we be accomplished for those residents found to have been affected by the deficient practice; -No residents were identified.	ith Food vill

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED
		155328	B. W	ING		03/10/2025
				CTREET	ADDRESS SITE STATE SID COD	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	
					DEHNE CAMP RD	
PARK IE	RRACE VILLAGE			EVANS	VILLE, IN 47712	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(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	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
					-The identified pitcher of swee	et
	Walk in refrigerator	:			tea, apple juice, lettuce, shred	
	One pitcher labeled				cheese, Canadian bacon,	
	1	,			meatballs, loaves of bread, ins	stant
	One pitcher labeled	apple juice, dated 2/28 use by			mashed potatoes, penne pasta	
	3/1	11 3 /			macaroni noodles, egg noodle	
	• •				zita rigate noodles, powdered	,
	One opened bag and	d two closed bags of wilting			sugar, puree rice mix were	
	lettuce, best by date				destroyed	
	1000000, 0000 09 0000	2, 25, 25			-The identified scoop , stove a	nd
	Bag of sliced Ameri	ican cheese, opened 2/26 use			top of stove, was thoroughly	ilu
	3/4	real energy opened 2/20 use			cleaned	
	3/ 1				•How other residents having	
	Bag of shredded cheese, opened 2/26 use 3/4				the potential to be affected by	.,
	Dag of sificaded circ	cese, opened 2/20 use 3/4			the same deficient practice w	- I
	Rag of mozzarella o	cheese open to air, opened 2/24			be identified and what	/III
	use by 3/3	neese open to an, opened 2/24	corrective action(s) will be			
	use by 3/3				taken;	
	Walk in freezer:				-All residents have the potenti	al to
		con, dated 2/6 use by 2/9			be affected by the alleged defi	
	Dag of Calladian ba	con, dated 2/0 use by 2/9			practice.	Clefft
	Bag of meatballs, da	atad 2/20			-All food items with no date or	
	Dag of illeatoalis, da	ated 2/20			past expiration date were	
	Dury atomorou					
	Dry storage:	1.1. 4. (1			discarded including sweet tea,	
	Box of loaves of bre	ead directly on floor			apple juice, bags of lettuce,	
	0 11 61 4	. 1 1 1 .			American cheese, shredded	
	Opened bag of insta	ant mashed potatoes, no date			cheese, mozzarella cheese,	
	0 1 0	1 . 11/10			Canadian bacon, bag of meath	
	Opened of penne pa	ista, dated 1/18			penne pasta, macaroni noodle	S,
	0 1 0				egg noodles, zita noodles,	
	Opened of macaron	i noodles, no date			powdered sugar, rice mix.	
					-Food items are not being stor	ed
	Opened bag of egg	noodles, no date			in boxes on the floor.	
					-Floor around the stove and st	ove
	Opened bag of zita	rigate noodles, no date			topped were cleaned.	
					-Walk through area, dry storag	`
	Box of powdered su	igar, open to air			area was inspected to ensure	
					food was appropriately labeled	
	Box of puree rice m	ix, open to air			discarded if outdated. The kitc	
					was thoroughly cleaned by die	tary

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPLETED			ETED
		155328	B. W	ING		03/10/	2025
		l .	1	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				DEHNE CAMP RD		
	RRACE VILLAGE				VILLE, IN 47712		
I ANN IE	TOTALE VILLAGE			LVAINS	VILLE, IIN 7// 12		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY 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)		DATE
		p with residue sitting directly			manager/designee		
	on open shelf				•What measures will be put		
					into place and what systemic	C	
		and top of stove dirty with			changes will be made to		
	food debris				ensure that the deficient		
					practice does not recur;		
		.M., the Dietitian indicated			-Kitchen staff will be educated	•	
		led and dated according to the			the Culinary manager/designe	ee	
	facility policy.				regarding food storage and		
					labeling.		
		A.M., the Administrator			-Culinary Manager/designee v		
		tled Food Storage, revised			complete daily rounds to ensu		
		"4. Scoops should be kept		food items are labeled and stored		ored	
	_	ted area near the containers. 6.			appropriately and to ensure		
		nimum 6" above the floor. 7.		cleanliness of the kitchen.			
		oods and processed meats are			•How the corrective action(s		
		red containers and wrapped			will be monitored to ensure t	the	
	· ·	must be clearly labeled and			deficient practice will not		
		e of the product, the date it			recur, i.e., what quality		
		narked to indicate the date by			assurance program will be p	ut	
		l be consumed or discarded.			into place		
		be held at 41 Fahrenheit (F) or			-The culinary manager/design	ee	
		in 3 days. The day the food			will be responsible for the		
		be counted as day 1. 8.			completion of the food storage	9	
		to eat, potentially hazardous			QAPI Tool weekly x4 weeks,		
	-	n approved vendors shall be			monthly x6 and then quarterly	untıl	
	•	the date the original container			continued compliance is		
	•	ate by which the food shall be			maintained for 2 consecutive		
		ded. This opened food can be			quarters. The results of these	!	
		for no more than 7 days and			audits will be reviewed by the	41	
	the date marked ma	-			QAPI committee overseen by		
		by date. 13. Dry storage			ED. If company threshold is no		
		ers must be used for storing			achieved, an action plan will b	e	
		and partial cases of bulk foods			developed. Deficiency in this		
		their original container. These			practice will result in disciplina	ıry	
		e labeled and dated on both			action up to and including		
		d. All food shall be covered or			termination of responsible		
	wrapped tightly, lab	beled, and dated.			employee.		
	3.1-21(i)(3)						
	J.1-41(1)(J)		1		i e e e e e e e e e e e e e e e e e e e		Ī

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY COMPLETED			
AND PLAN OF CORRECTION		155328	1	A. BUILDING 00 B. WING			03/10/2025	
		100020	J			00/10/	2020	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD			
PARK TERRACE VILLAGE				25 S BOEHNE CAMP RD EVANSVILLE, IN 47712				
PARK TERRACE VILLAGE				LV/(IVO	7VILLE, IIN 47712			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX			COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		+	TAG	DEFICIENCY 1		DATE	
	3.1-21(I)(2)							
F 0880	- 0880 483.80(a)(1)(2)(4)(e)(f)]	
SS=E								
Bldg. 00	and a solution							
Ĭ				380	It is the policy of the facility to		04/09/2025	
	Based on observation	on, record review, and			provide a safe, sanitary and comfortable environment and to help prevent the			
	interview, the facilit	ty failed to ensure infection						
	control practices and	d standards were performed						
	-	n observations. Staff observed			development and transmission			
		d hygiene during a medication		of communicable disea		nd		
	pass of B Hall, using Enhanced Barrier Protection				infections.			
		g gloves during care. (•What corrective action(s) will			
	Resident 28, Resident 39, Resident 19, Resident 48, Resident 41, Resident 18, Resident 22,				be accomplished for those residents found to have been			
	Resident 3)				affected by the deficient			
	Findings include: 1. On 3/6/25 at 7:19 A.M., during a random observation of a medication pass, Qualified Medication Aide (QMA) 14 failed to perform hand sanitization prior to entering Resident 28's room.				practice; -Resident #28, #39, #19, #48,			
					#41, #18, #22, and resident #3			
					were assessed with no effects			
					noted related to alleged deficie			
					practice.			
					-QMA#14, CNA # 6 and CNA #7			
On 3/6/25 at 7:25 A.M., during a random observation of a medication pass, QMA 14 failed to perform hand hygiene prior to entering and					were educated by infection			
		_			preventionist regarding infection			
				control practices including han	ıd			
				hygiene policy				
	exiting Resident 39's room.				•How other residents having			
	On 2/6/25 at 7,22 A	M. duning a non-dom			the potential to be affected b	-		
On 3/6/25 at 7:32 A.M., during a random observation of a medication pass, QMA 14 failed to perform hand hygiene prior to entering and				the same deficient practice was be identified and what	/111			
				corrective action(s) will be				
	exiting Resident 19's room.				taken;			
					-All residents have the potenti	ial to		
	On 3/6/25 at 7:38 A.M., during a same random				be affected by the alleged defi			
		dication pass, QMA 14			practice.	·		
		without performing hand			-QMA#14, CNA # 6 and CNA	# 7		
		Resident 48's room.			were educated by infection			
On 3/6/25 at 7:45 A.M., during a randon					preventionist regarding infection	on		
		.M., during a random			control practices including han	ıd		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		ONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			00	COMPLETED
		155328	B. WING			03/10/2025
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>
NAME OF PROVIDER OR SUPPLIER					OEHNE CAMP RD	
PARK TERRACE VILLAGE					SVILLE, IN 47712	
					, - T	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION		TAG		DATE
		edication pass, QMA 14 failed			hygiene policy.	
	_	giene prior to entering and			-All staff will be educated on	
	exiting Resident 41's room.			infection control practices,		
	On 2/6/25 at 7:50 A	A.M., during a random			including hand hygiene and	
		edication pass, QMA 14 failed			enhanced barrier policy.	
		giene prior to entering		•What measures will be put		
	Resident 18's room.			into place and what systemic		
	Resident 18 8 100m.	•		changes will be made to ensure that the deficient		
	During an interview	on 3/7/25 at 11:01 A.M., the			practice does not recur;	
	_	nist indicated staff should			-The infection	
		ene before they touch			preventionist/designee will	
		ing into a resident's room, and			complete daily rounds to ensu	ıre
		sident. 2. On 3/7/25 at 8:39			appropriate infection control	ii e
	_				techniques are utilized.	
	A.M., Certified Nurse Aide (CNA) 6 was observed performing incontinence care for Resident 22.				The Infection	
	CNA 6 was not wearing a gown. An Enhanced				preventionist/designee will	
	Barrier Precaution (EBP) sign was observed above				complete skills validations on	
	Resident 22's bed. The sign indicated that staff				hand hygiene as well as PPE	IISA
	should wear a gown and gloves during high				skills validations.	use
	contact care.				•How the corrective action(s	a
	contact care.				will be monitored to ensure	•
	On 3/7/25 at 9:25 A.M., Resident 22's clinical				deficient practice will not	
	record was reviewed. Diagnoses included, but			recur, i.e., what quality		
	were not limited to, dementia and stage two				out	
	pressure ulcer.				assurance program will be p into place	
	[*				-The IP/designee will be	
	The most recent Significant Change Minimum				responsible for the completion	n of
	Data Set (MDS) Assessment, dated 2/17/25,				the infection prevention QAPI Tool	
	indicated Resident 22 had severe cognitive				weekly x4 weeks, monthly x6	
	impairment, was dependent on staff for toileting,				then quarterly until continued	
	and did not have a pressure ulcer.				compliance is maintained for 2	
	•				consecutive quarters. The re-	
	Current care plans included, but were not limited				of these audits will be reviewe	
	to:				the QAPI committee overseer	n by
	Resident is at risk of transferring or becoming				the ED. If company threshold	-
	colonized with an N	Multi-Drug Resistant			not achieved, an action plan v	
	Organizisms (MDRO) and requires enhanced				be developed. Deficiency in the	
	barrier precautions due to a chronic wound that				practice will result in disciplina	
requires a dressing, dated 3/5/25					action up to and including	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUC		NSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED			
		155328	B. WING		· ·	03/10/2025			
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD				
NAME OF P	ROVIDER OR SUPPLIER	1							
DARK TERRACE VIII A OF				25 S BOEHNE CAMP RD					
PARKIE	RRACE VILLAGE			EVANS	VILLE, IN 47712				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI			(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL					COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
					termination of responsible				
	A Wound Managen	nent Observation note, dated			employee.				
	3/5/25 at 10:30 A.N	1., indicated Resident 22 had a							
	stage two pressure t	alcer on the right side of her							
	sacrum.								
	On 3/7/25 at 10:22	A.M., the Director of Nursing							
		current list of residents who							
	were on EBP. Resi	dent 22 was listed.							
		A.M., the Director of Nursing							
		at residents on EBP had a care							
	-	id not have physician orders							
	for EBP.								
		A.M., the IP indicated that if a							
		P, staff should wear gown and							
	gloves during high								
	_	ration of incontinence care on							
		I., CNA 7 entered Resident 3's							
		hands, and put a gown and							
	-	aised Resident 3's bed with the							
		dent 3 to her side, and removed							
	her pants and soiled brief. CNA 7 used								
	-	to clean Resident 3. CNA 7							
	removed her gloves, applied hand sanitizer, put								
	new gloves on, and put a clean brief under								
	Resident 3. CNA 7 looked through Resident 3's								
	dresser and bedside table drawers with gloves on								
		n. CNA 7 applied barrier cream							
	on Resident 3's bottom, wiping the cream over the								
	wounds on Resident 3's coccyx and left gluteal								
	fold. CNA 7 removed her soiled glove, put a new glove on, and rolled Resident 3 back over and								
	-								
	assisted pulling her	oriei and pants up.							
	On 2/10/25 -+ 11 00	A.M. the Administration							
		A.M., the Administrator							
	provided a current policy "Hand Hygiene Policy" revised in 12/21. The policy indicated "hand								
hygiene applies to hand washing, antiseptic hand									

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/31/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155328	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/10/2025			
NAME OF PROVIDER OR SUPPLIER PARK TERRACE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 25 S BOEHNE CAMP RD EVANSVILLE, IN 47712					
(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	
	wash, and alcohol based hand rubmoments of hand hygiene includebefore touching a patient, after body fluid risk, and after touching a resident" On 3/10/25 at 11:00 A.M., the Administrator provided a current undated Enhanced Barrier Precautions policy that indicated "Use of personal protective equipment - gown and gloves - during high-contact resident care activitieschanging briefs or assisting with toileting Gloves and gown prior to the high-contact care activity". 3.1-18(b)(2) 3.1-18(l)							

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