STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155726		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 01/24/2023	
	PROVIDER OR SUPPLIEF		400 CA	ADDRESS, CITY, STATE, ZIP COD AYLOR BLVD FTON, IN 46714	
(X4) ID PREFIX TAG	(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)	(X5) COMPLETION DATE
F 0000					
Bldg. 00	Licensure Survey. Residential Licensure Survey dates: Janua Facility number: 0 Provider number: 1 AIM number: 2003  Census Bed Type: SNF/NF: 28  Total: 28  Census Payor Type Medicare: 1  Medicaid: 27  Total: 28	nry 19, 20, 23, and 24, 2023.  03575  55726  95060	F 0000		
F 0758 SS=D Bldg. 00	accordance with 41  Quality review com  483.45(c)(3)(e)(1)  Free from Unnec Use §483.45(e) Psych §483.45(c)(3) A p drug that affects b with mental proce	0 IAC 16.2-3.1.  apleted January 25, 2023.  -(5) Psychotropic Meds/PRN  otropic Drugs. sychotropic drug is any orain activities associated sses and behavior. These are not limited to, drugs in gories:  at;			

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

TITLE (X6) DATE

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 disclodays 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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CENTERS FO	R MEDICARE & MEDIC	_			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155726		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/24/2023	
	PROVIDER OR SUPPLIEI		400 CA	ADDRESS, CITY, STATE, ZIP COD AYLOR BLVD TON, IN 46714	
(X4) ID PREFIX TAG	(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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	Based on a compresident, the facili §483.45(e)(1) Respondition documented in the §483.45(e)(2) Responditions, and bunless clinically of to discontinue the §483.45(e)(3) Responditions to discontinue the §483.45(e)(3) Responditions that medical diagnosed specific documented in the §483.45(e)(4) PR drugs are limited provided in §483.45(e)(4) PR drugs are limited provided in §483.45(e)(5) PR drugs are limited extended beyond document their ramedical record are the PRN order.	rehensive assessment of a ty must ensure that sidents who have not used is are not given these drugs ation is necessary to treat a as diagnosed and e clinical record; sidents who use is receive gradual dose ehavioral interventions, ontraindicated, in an effort	F 0758	Plan of Correction Annual	02/10/2023

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failed to ensure adverse side effects of

psychotropic medications were monitored for 1 of

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Survey and Re-Certification

1/19-1/24/2023:

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STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING	<u>00</u> COMI		ATE SURVEY  OMPLETED  /24/2023	
		155726	B. WING		01/24	/2023	
	PROVIDER OR SUPPLIER		400 CA	ADDRESS, CITY, STATE, ZIP COD NYLOR BLVD TON, IN 46714			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	l	_	(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E E	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE	
TAG	Findings include:  Resident 18's record 10:30 AM. Diagnos disease with early of disorder, single episted dementia, unspecific disturbance, and an unspecified, major of severe without psychotic subsequent encount unspecified severity depressive disorder psychotic symptom classified elsewhere psychotic disturband disorder, restlessness interview for menta 11/15/2022, indicat (severe cognitive in 1. A current care plus behavior problem redisorder with behave hopelessness and an Resident 18 would of anxiousness each more than 2 episode or feeling down threinterventions included or defects and effective A physician order, or disorder, ordered and monito effects and effective and effec	d (Resident 18).  d was reviewed on 1/20/2023 at sees included Alzheimer's snset, major depressive sode, unspecified, vascular ed severity, without behavioral stic disturbance, mood xiety, anxiety disorder, depressive disorder, recurrent shotic features, adverse effect tics and neuroleptics, er, unspecified dementia, which agitation, major precurrent, severe with seed, unspecified severity, with seed, generalized anxiety seen and agitation. A brief al status assessment, dated ed Resident 18 had score of 3 mpairment).  The goal indicated had a selated to major depressive siors such as sense of the seed and would not have the per week of feeling hopeless ough the next review. The led administer medications as in for and document side	TAG	R 000  By submitting the enclosed materials, we are not admitt truth or accuracy of any spe findings or allegations. We reserve the right to contest of findings or allegations as particle any proceedings and submit responses pursuant to our regulatory obligations. The request that the plan of corresponse of the annual licent survey completed January 2023. The facility also request that our plan of correction be considered for paper review compliance. The facility will submit any evidence as request to validate compliance.  F758  It is the practice of this fact to assure that residents are being monitored for any adverse side effects involved with taking psychotropic medications.  The corrective action takent those residents found to be affected by the deficient princlude:  Resident #18 medication reviewer corrected to include documentation to monitor for psychotropic side effects on eMar and also in the nurses in the event of adverse side effects.  How other residents that he	ing the cific  he rt of these facility ection ruary sure (4, ests)  uested  ility  e red  for e ractice  cords  r the notes	DATE	

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medication used to treat anxiety- nervousness),

Event ID:

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the potential to be affected have

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STATEMENT OF DEFICIENCIES X1) PR		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		00		COMPLETED	
		155726	B. W			01/24		
				OTD PPT	ADDRESS SITE OF THE STREET			
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
DIVED T	ERRACE HEALTH	CARE CENTER			YLOR BLVD TON, IN 46714			
RIVER	ERRAGE DEALIH	CARE CENTER		DLUFF	I ON, IIN 40/ 14			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE	
	-	outh 2 times a day related to			been identified by:			
	anxiety disorder.				All residents that receive			
		1 . 10/2/2022 1 77			psychotropic medications have			
		dated 8/3/2022, indicated to			potential to be affected. Audit			
		ing due to antianxiety			were completed on the orders			
		serve closely for significant			medication administration rec			
		on (a state of calm or asleep),			of those residents on psychot	-		
	· ·	(drunk walk), dizziness, nausea,			medications that monitoring w			
	-	n, headache, blurred vision,			in place and documentation w			
		(yes) if monitored and none of			present in the progress notes			
		ns was observed. Click N (no) if			adverse side effects were pre			
	1	of the above symptoms was			Measures and systemic cha	nges		
		t chart code "other/see nurse's indings. There was no			put in place to prevent			
		nd in the Nurses Notes (NN)			reoccurrence:			
		ng for adverse (bad) side			The policy on monitoring of adverse side effects of			
	effects of antianxie	- · · · · · · · · · · · · · · · · · · ·						
	effects of antianxle	by medication.			psychotropic monitoring was			
	An MAR ( Medica	yion Administration Record),			reviewed by the IDT team. Ar inservice was held with the	ı		
		)22, indicated Resident 18 was			licensed nurses and social			
		on, Buspirone HCL 5mg tablet,			services on how to correctly v	vrite		
	-	each day at 8:00 AM and 8:00			orders to ensure side effect	VIIIC		
		documentation to indicate side			monitoring is being completed	d and		
		cation were monitored.			documenting in the progress			
	land in Cui				when adverse side effects are			
	An MAR, dated Jan	nuary 2023, indicated Resident			present. A performance	-		
		nedication, Buspirone HCL 5mg			improvement tool has been			
	_	times each day at 8:00 AM and			developed to audit psychotrop	oic		
		y 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12,			side effect monitoring and			
		19, 20, 21, and 22. On January 15			documentation of adverse sid	е		
		8 had only been give the 8:00			effects.			
		as no documentation indicating			Corrective Action(s) monito	ring		
		medication were monitored.			and Quality Assurance	•		
					Programs:			
	2. A physician orde	er, dated 10/8/2022, indicated to			A performance improvement	tool		
	give Venlafaxine H	ICl ER 150mg extended release			has been initiated that randor			
	24-hour capsule (a	medication used to treat			checks five (5) residents to er	-		
	depression), give 1	capsule by mouth 1 time a day			that monitoring is being comp			
	related to major de	pressive disorder, single			for side effects of psychotropi			
	episode, unspecifie				medications and adverse effe			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPL	ETED
		155726	B. WING 01/24/2023			2023	
				CED FEET	DDDEGG CUTY CTATE JID COD		
NAME OF P	ROVIDER OR SUPPLIER	t e e e e e e e e e e e e e e e e e e e			ADDRESS, CITY, STATE, ZIP COD		
DIVED T		OADE OENTED			YLOR BLVD		
RIVER II	ERRACE HEALTH	CARE CENTER		BLUFF	ΓΟΝ, IN 46714		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWINEDIG BY AN 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	•	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
					are being documented in the		
	A physician order	dated 8/3/2022, indicated to			progress notes. This Quality		
		ng due to antidepressant			Assurance Audit Tool will be		
		nitor for significant side			completed by the Director of		
		dry mouth, blurred vision,					
					Nursing/ Designee Weekly for		
	urinary retention (un	art rate), muscle tremor,			three weeks; then monthly for		
	` `				three months, then quarterly x		
	-	skin rash, photosensitivity			three. In the event any further		
	· ·	e sun/light), excess weight			concerns are identified, the iss		
	` '	f monitored and any of the			will be immediately corrected a		
		as observed and select chart			additional training will be initiat	ted.	
		se's notes" and record			Results of the audit will be		
	_	no documentation found in			reviewed at the Quality Assura	nce	
		Nurses Notes (NN) regarding			Meeting at least quarterly.		
	monitoring for adve				Date systemic changes will b	e	
	antidepressant medi	cation.			completed:		
					February 10, 2023		
	An MAR, dated De	cember 2022, indicated					
	Resident 18 was giv	ven the medication, Venlafaxine					
	HCl ER 150mg exte	ended release 24-hour capsule, 1					
	capsule every day a	t 8:00 AM. There was no					
	documentation indi	cating side effects of this					
	medication were mo	onitored.					
	A MAR, dated Janu	ary 2023, indicated Resident					
		edication, Venlafaxine HCl ER					
	_	ease 24-hour capsule, 1					
	_	t 8:00 AM on January 1, 2, 3,					
		1, 12, 13, 14, 15, 16, 17, 18, 19, 20,					
		re was no documentation					
	· · ·	ets of this medication were					
	monitored.	of this incuration were					
	momorou.						
	3 A current care no	an indicated Resident 18 took					
	_	ations related to major					
		with behaviors. The goal					
	•	C					
		18 would have no side effects					
		psychotic medication through					
		e interventions iadminister					
	ncluded medication	s as ordered, monitor for and					

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CENTENS FOR MEDICARE & MEDICAID SERVICES				NAME AND ADDRESS OF THE PARTY O		1B NO. 0936-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CC		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00		COMPLETED	
		155726	B. WING		01/24	/2023	
			STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	8		YLOR BLVD			
RIVER T	ERRACE HEALTH	CARE CENTER	BLUFF"	TON, IN 46714			
(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 B	E	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE	
		cts and effectiveness, consult					
		medical doctor was to					
		luction when clinically					
	1	or, record and report to the					
		effects and adverse reactions					
		dication: unsteady gait					
		lyskinesia (uncontrollable					
		ace and body), shuffling gait,					
		ing, frequent falls, refusal to					
	_	owing, dry mouth, depression,					
	1	thoughts of harming self),					
		t wanting to interact with					
	,	ion, diarrhea, fatigue, insomnia					
	· · · · · · · · · · · · · · · · · · ·	oss of appetite, weight loss,					
	* / /	isea, vomiting, behavior					
		l to the resident), and social					
		eded. A physician order, dated					
		red Risperidone 0.25mg tablet (a					
		treat psychosis, a mental					
		zed by a disconnection from					
		(2) tablet by mouth 1 time a day					
		pressive disorder, recurrent,					
	severe with psychol						
	severe with psychol	tie symptoms.					
	A physician order	dated 12/17/2022, indicated					
		g tablet, give 1 tablet by mouth					
		I to major depressive disorder,					
		ith psychotic symptoms.					
		p					
	A physician order,	dated 8/3/2022, indicated					
		cation use: observe closely for					
		ects: sedation, drowsiness, dry					
	~	n, blurred vision, extra					
		(inability to sit still, involuntary					
	* *	s, tremors, stiff muscles, and					
		novements), weight gain,					
	1	om retaining fluid), postural					
		pressure drop with position					
		loss of appetite, urinary					
		yes) if monitored and none of					

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VCX011

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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 00	(X3) DATE SURVEY COMPLETED 01/24/2023	
NAME OF PROVIDER OR SUPPLIER RIVER TERRACE HEALTH CARE CENTER		400 CA	ADDRESS, CITY, STATE, ZIP COD NYLOR BLVD TON, IN 46714		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE	E COMPLETION
PREFIX TAG	the above symptom monitored and any observed and select notes" and record fi documentation four regarding monitorir antipsychotic medical An MAR, dated De Resident 18 was given it was no docur effects of this medical An MAR, dated De Resident 18 was given it was no docur effects of this medical An MAR, dated De Resident 18 was given it was no docur effects of this medical An MAR, dated De Resident 18 was given it was no docur effects of this medical An MAR, dated Jar 18 was given the mutablet, ½ tablet even	s was observed. Click N (no) if of the above symptoms was chart code "other/see nurse's ndings. There was no ad in the Nurses Notes (NN) ag for adverse side effects of cation.  cember 2022, indicated ven the medication, g tablet, ½ tablet every day at ber 24,25,26,27,28,29, 30, and 31. mentation indicating side cation were monitored.	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B)	E COMPLETION
	20, 21, and 22. The regarding the Janua documentation indimedication were medication which was given the medication that the medication was given the medication which was given the medication was	ere was no documentation ry 15 dose. There was no cating side effects of this			
	2, 3, 4, 5, 6, 7, 8, 9, 19, 20, 21, 22, and 2	10, 11, 12, 13, 14, 15, 16, 17, 18, 23. There was no documentation ets of this medication were			

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VCX011 Facility ID: 003575

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

PRINTED: 03/14/2023 FORM APPROVED OMB NO. 0938-039

	ENT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155726	UILDING	instruction 00	(X3) DATE COMPL <b>01/24</b> /	ETED
NAME OF PROVIDER OR SUPPLIER RIVER TERRACE HEALTH CARE CENTER			400 CA	NDDRESS, CITY, STATE, ZIP COD YLOR BLVD FON, IN 46714		
(X4) ID PREFIX TAG	(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
	Practitioner), dated requested a visit for dementia, anxiety, agitation history. Repsychiatric assessme psychiatric condition behaviors and control his psychotropic management. Resident 18 was stagain. Resident 18 hagitation that day. It quiet, calm with not depression or overwell medications include and Risperidone. The she would continue response to the medications. Staffor Resident 18 for any memory, appetite, a reviewed for potent psychotropic medication by the formal interview, on indicated side effect antipsychotic, anticoagulant medications glucose check the control of the proper state of the proper side of	rider's Psychiatric Note (Nurse 1/5/2023, indicated the facility of Resident 18 to follow up for depression with behaviors and esident 18 was seen for ment of his described ons, assessment of mood and inued evaluation of efficacy of edications. Staff reported able, had no weight loss or ad no reported anxiety or Resident 18 was described as restlessness, agitation, whelming anxiety. Psychiatric ed Buspar, Effexor, Aricept, the Nurse Practitioner indicated to monitor Resident 18's dication and note any trends in the second of the first of side effects from current was to continue to observe or changes in sleep, moods, and/or behaviors. Labs were tial adverse effects to eations.  Ses Notes, dated 12/24/2022 to do no documentation of effects of psychotropic facility nursing staff.  1/24/2023 at 10:05 AM, LPN 3 at were to be monitored for depressant, antianxiety, cations. Residents receiving formitored for side effects and tents receiving Insulin had their ked and were monitored for we blood sugar levels.				

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Event ID:

VCX011

Facility ID: 003575

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	A. BUILDING <u>00</u>			COMPLETED	
		155726	B. WING 01/24/2023				/2023	
		<u> </u>	<u> </u>	CTDEET A	ADDRESS CITY STATE ZID COD			
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD YLOR BLVD			
DIVED T		CARE CENTER						
RIVER I	ERRACE HEALTH	CARE CENTER		BLUFF	TON, IN 46714			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	Residents were to b	be monitored for side effects						
	throughout the shif	t and documented once a shift.						
	Documentation was	s done on the MAR.						
	In an interview, on	1/24/2023 at 10:10 AM, the						
	Director of Nursing	g (DON) indicated side effects						
	were to be monitor	ed for antipsychotic,						
	antidepressant, and	anticoagulant medications.						
	Monitoring should	be done every shift and was to						
	be documented on	the resident's MAR.						
	A current policy, ti	tled Psychotropic Medication						
	Use, dated 11/28/20	017, was received from the DON						
	on 1/24/2023 at 10:	:54 AM. The policy indicated,						
	Policy "A psychotr	opic drug is any drug that						
	affects brain activit	ies associated with mental						
	processes and beha	vior. These drugs include, but						
		drugs in the following						
	categories: 1. Anti-	psychotic 2. Anti-depressant 3.						
	Anti-anxiety 4. Hy	pnotic Residents who receive						
	psychotropic medic	cations will have their						
	drug/medication re	gimen managed and monitored						
	to promote or main	tain the resident's highest						
	practicable mental,	physical, and psychosocial						
	well-being Guide	elines14. Nursing staff shall						
	monitor for and rep	oort any of the following side						
	effects and adverse	consequences to the						
	physician such as:	a. general/anticholinergic:						
		ed vision, dry mouth, urinary						
	retention, sedation	b. cardiovascular: orthostatic						
	hypotension (drop i	in blood pressure when						
		), arrythmias (irregular heart						
		olic: increase in total						
	cholesterol/triglyce	rides, unstable or poorly						
		gar, weight gain d. neurologic:						
	akathisia (feeling o	f muscle quivering,						
	, -	ability to sit still), dystonia						
		sustained or repetitive muscle						
		in twisting and repetitive						
		ormal fixed postures),						
	i e						•	

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

PRINTED: 03/14/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>00</u>		COMPLETED		
		155726	B. WING	3		01/24/2023	
NAME OF PROVIDER OR SUPPLIER  RIVER TERRACE HEALTH CARE CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE			400 CAY	DDRESS, CITY, STATE, ZIP COD /LOR BLVD ON, IN 46714		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
R 0000	extrapyramidal effectimpairment of move neurological disorder movements of the fatransient ischemic at Physician shall respectanging or stopping medications, or clear assessing the situation	ets, akinesia (loss or ement), tardive dyskinesia ( a er characterized by involuntary ace and jaw), stroke or ttack (" mini stroke"). 15. The ond appropriately by g problematic doses or rly documenting (based on on) why the benefits of the h the risks or suspected or					
Bldg 00							
Bldg. 00	Survey. This visit in State Licensure Survey Survey dates: Januar Facility number: 00% Residential Census: River Terrace Heath in compliance with a State Residential Lice	ry 19, 20, 23, and 24, 2023.  3575  41  a Care Center was found to be 410 IAC 16.2-5 in regard to the censure Survey.	R 000	0			
	Quality review com	pleted January 25, 2023					

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