STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155726		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 02/07/2023		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 400 CAYLOR BLVD BLUFFTON, 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)	ΓE	(X5) COMPLETION DATE
E 0000	REGULATORT OR	LISC IDENTIFTING INFORMATION		TAG			DATE
Bldg	conducted by the In accordance with 42  Survey Date: 02/07  Facility Number: 00  Provider Number: 1  AIM Number: 2003  At this Emergency 1  Terrace Healthcare substantial complian  Preparedness Requi Medicaid Participat  CFR 483.73. The face	27/23 23575 55726 95060  Preparedness survey, River Center was found in nee with Emergency rements for Medicare and ing Providers and Suppliers, 42 will the time of this survey.	E 00	000			
E 0037 SS=C Bldg	441.184(d)(1), 482.483.73(d)(1), 484.485.68(d)(1), 485.486.360(d)(1), 497.5486.3748(d)(1), \$4841.184(d)(1), \$4841.184(d)(1), \$483.73(d)(1), \$485.68(d)(1), \$485.68(d)(1). \$491.12(d)(1). \$491.12(d)(1). \$491.12(d)(1).	am 116.54(d)(1), §418.113(d)(1), 160.84(d)(1), §482.15(d)(1), 33.475(d)(1), §484.102(d)(1), 85.625(d)(1), §485.727(d)					
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SIC	NATURI	3	TITLE		(X6) DATE

(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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: VCX021 Facility ID: 003575 If continuation sheet Page 1 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	LETED
		155726	B. W	ING		02/07	/2023
				CEDEET	ADDRESS STEV STATE TIP SOD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
חויירם ד		OADE OFNITED			YLOR BLVD		
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	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	at §491.12:]						
	(1) Training progr	ram. The [facility] must do					
	all of the following	<b>:</b>					
	(i) Initial training in emergency preparedness						
	policies and proce	edures to all new and					
	existing staff, indiv	viduals providing services					
	under arrangemer	nt, and volunteers,					
	consistent with the	eir expected roles.					
	(ii) Provide emerg	ency preparedness training					
	at least every 2 ye	ears.					
	(iii) Maintain docu	mentation of all emergency					
	preparedness trai	ning.					
	(iv) Demonstrate staff knowledge of						
	emergency proced	dures.					
		cy preparedness policies					
	and procedures a	re significantly updated, the					
		duct training on the					
	updated policies a	and procedures.					
	*[For Hospices at	§418.113(d):] (1) Training.					
		do all of the following:					
	· ·	n emergency preparedness					
	.,	edures to all new and					
		employees, and individuals					
		s under arrangement,					
	consistent with the	eir expected roles.					
	(ii) Demonstrate s	taff knowledge of					
	emergency proced						
	(iii) Provide emerg	gency preparedness training					
	at least every 2 ye	ears.					
	(iv) Periodically re	view and rehearse its					
	emergency prepa	redness plan with hospice					
	employees (includ	ling nonemployee staff),					
	with special emph	asis placed on carrying out					
	the procedures necessary to protect patients						
	and others.						
	(v) Maintain documentation of all emergency preparedness training.						
	(vi) If the emerger	ncy preparedness policies					
	and procedures are significantly updated, the						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VCX021 Facility ID: 003575

If continuation sheet Page 2 of 21

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155726	ì	UILDING	NSTRUCTION	(X3) DATE COMPI 02/07	LETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 400 CAYLOR BLVD BLUFFTON, IN 46714					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N BE PRIATE	(X5) COMPLETION	
TAG		a LSC IDENTIFYING INFORMATION  duct training on the  and		TAG	DEFICIENCY		DATE	
	program. The PR' following: (i) Initial training in policies and proceexisting staff, indivunder arrangement consistent with the (ii) After initial train preparedness traic (iii) Demonstrate semergency proceeciv) Maintain document preparedness traic (v) If the emergency and procedures a	ning, provide emergency ning every 2 years. staff knowledge of dures. mentation of all emergency ning. cy preparedness policies re significantly updated, the act training on the updated						
	organization must (i) Initial training ir policies and proce existing staff, individed in the context of the co	ency preparedness training						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VCX021 Facility ID: 003575

If continuation sheet

Page 3 of 21

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	<u></u>	COMPL	ETED	
		155726	B. W	ING _		02/07/	/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF 1	PROVIDER OR SUPPLIE	R			YLOR BLVD			
RIVER T	ERRACE HEALTH	CARE CENTER			TON, IN 46714			
INVERT	- CHIVIOL HEALTH	Of the Gentlert		DEGIT				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		uct training on the updated						
	policies and proce	edures.						
	_	es at §483.73(d):] (1)						
	Training Program. The LTC facility must do all							
	of the following:							
	· · ·	n emergency preparedness						
	1 '	edures to all new and						
	_	viduals providing services						
	_	nt, and volunteers,						
	consistent with their expected role.  (ii) Provide emergency preparedness training at least annually.  (iii) Maintain documentation of all emergency							
	preparedness trai	<b>.</b>						
		staff knowledge of						
	emergency proce	_						
	cinergency proce	dures.						
	*IFor CORFs at 8	485.68(d):](1) Training. The						
	CORF must do al							
		raining in emergency						
	1 ' '	icies and procedures to all						
		staff, individuals providing						
	_	rangement, and volunteers,						
		eir expected roles.						
		gency preparedness training						
	at least every 2 ye	ears.						
	1	mentation of the training.						
	, ,	staff knowledge of						
	emergency proce	dures. All new personnel						
	must be oriented	and assigned specific						
		garding the CORF's						
	emergency plan v	vithin 2 weeks of their first						
	1	ning program must include						
	instruction in the location and use of alarm							
	systems and signals and firefighting							
	equipment.							
	(v) If the emergency preparedness policies							
	and procedures a	re significantly updated, the						
	CORF must conduct training on the updated							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<del></del>	COMPLETED	
		155726	B. WING		02/07/2023	
			STREE	T ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	¢ .	400 C	AYLOR BLVD		
	ERRACE HEALTH	CARE CENTER	BLUF	FTON, IN 46714		
(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	DEFICIENC!)	DATE	
	policies and proce	edures.				
	*[For CAHs at §485.625(d):] (1) Training					
	program. The CAH must do all of the					
	following:	Tillust do all of the				
	_	n emergency preparedness				
		edures, including prompt				
	reporting and extir	• • • • • • • • • • • • • • • • • • • •				
		nere necessary, evacuation				
	•	nnel, and guests, fire				
		poperation with firefighting				
	•	orities, to all new and				
	existing staff, indiv	viduals providing services				
	under arrangemer	nt, and volunteers,				
	consistent with the	eir expected roles.				
	(ii) Provide emerg	ency preparedness training				
	at least every 2 ye					
	, ,	mentation of the training.				
	, ,	staff knowledge of				
	emergency proced					
	, ,	ncy preparedness policies				
		re significantly updated, the				
		ct training on the updated				
	policies and proce	edures.				
	*[For CMHCs at &	485.920(d):] (1) Training.				
		provide initial training in				
		redness policies and				
		new and existing staff,				
	•	ng services under				
	arrangement, and	volunteers, consistent with				
	their expected role	es, and maintain				
		the training. The CMHC				
		staff knowledge of				
		dures. Thereafter, the				
	CMHC must provi					
		ning at least every 2 years.				
		view and interview, the facility	E 0037	E037	03/03/2023	
		inual training for the		It is the practice of this facili	ty	
	Emergency Prepare	dness Program (EPP). The LTC		to develop and maintain an		

PRINTED: 03/10/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155726		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY  COMPLETED  02/07/2023	
	ROVIDER OR SUPPLIER		400 CA	ADDRESS, CITY, STATE, ZIP COD AYLOR BLVD FTON, 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 BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
	facility must do all training in emergen procedures to all ne individuals providir and volunteers, con roles; (ii) Provide et training at least and documentation of all training; (iv) Demotemergency procedu 483.73(d) (1). This all residents in the findings include:  Based on record revand the Maintenance a.m., there was doct for EPP training dad documentation of wand to show staff co of the EPP. Based or records review, the Maintenance Direct trained on the compcould not find documentation of the trained on the compcould not find documentation of the finding was revenue.	et LSC IDENTIFYING INFORMATION of the following: (i) Initial cy preparedness policies and w and existing staff, ag services under arrangement, sistent with their expected mergency preparedness ually; (iii) Maintain all emergency preparedness anstrate staff knowledge of ares in accordance with 42 CFR deficient practice could affect facility.  The with the Administrator are Director on 02/07/23 at 10:59 amentation of a sign in sheet and 02/22/22; but there was no and that the training consisted of build demonstrate knowledge and an interview at the time of Administrator and the or stated all staff have been allete EPP in the last year but mentation to show staff could		emergency preparedness training and testing prograt upon hire and annually. Evidence of the training mube maintained, and staff mube able to demonstrate understanding.  The corrective action taken those residents found to be affected by the deficient princlude:  There are no specific resididentified.  Other residents that have a potential to be affected have been identified by:  Potentially all residents combe affected.  The measures or systematic changes that have been pupilize to ensure that the deficient practice does not include:  The Administrator is responsible for assuring the the emergency preparedness policy and procedure has be reviewed and updated to include a post test for	m st ust u
				demonstration of knowledg	e of

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VCX021 Facility ID: 003575

If continuation sheet

Page 6 of 21

PRINTED: 03/10/2023 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING COMPLETED				
		155726	B. W			02/07/	
	PROVIDER OR SUPPLIER			400 CA	ADDRESS, CITY, STATE, ZIP COD YLOR BLVD TON, IN 46714		
RIVER T  (X4) ID  PREFIX  TAG	SUMMARY (EACH DEFICIEN	CARE CENTER  STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION				ort eir to ure	(X5) COMPLETION DATE
E 0039 SS=C Bldg	441.184(d)(2), 482	5.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), 102(d)(2), 485.625(d)(2)			preparedness policy and procedure manual at a minimum of annually and update accordingly. Human resources will audit personn files to ensure compliance a report findings in QAPI.  The date the systemic chan will be completed.  March 3, 2023	nd	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VCX021

Facility ID: 003575

If continuation sheet

Page 7 of 21

PRINTED: 03/10/2023 FORM APPROVED OMB NO. 0938-039

	IENT OF DEFICIENCIES AN OF CORRECTION	IDENTIFICATION NUMBER  155726		UILDING	nstruction 	COMPI 02/07	LETED	
	F PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 400 CAYLOR BLVD BLUFFTON, 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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	485.68(d)(2), 485 486.360(d)(2), 49 EP Testing Requi §416.54(d)(2), §4 §460.84(d)(2), §4 §483.475(d)(2), § 485.625(d)(2), § (2), §491.12(d)(2)  *[For ASCs at §4* OPO, "Organizatic CMHCs at §485.9 §491.12, and ESF  (2) Testing. The [if exercises to test to annually. The [fact following:  (i) Participate in a community-based (A) When a community-based (A) When a community-based (B) If the [fact following or functional exercises exempt from exercise actual event.  (ii) Conduct an additional exercise actual event.  (iii) Conduct an additional exercise actual e	.727(d)(2), 485.920(d)(2), 1.12(d)(2), 494.62(d)(2) rements 18.113(d)(2), §441.184(d)(2), 82.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d) 4, §494.62(d)(2).  16.54, CORFs at §485.68, 60s" under §485.727, 620, RHCs/FQHCs at RD Facilities at §494.62]:  16.61 facility] must conduct 16 he emergency plan 16 full-scale exercise that is 16 every 2 years; or 17 munity-based exercise is 18 every 2 years; or 18 every 2 years; or 19 munity-based exercise is 19 every 2 years; or 19 experiences an actual 19 ede emergency that requires 19 energency plan, the [facility] 19 experiences an actual 29 every plan, the [facility] 20 experiences at least 20 erindividual, facility-based 21 erindividual, facility-based 22 erinder paragraph (d)(2) 23 s conducted, that may 24 limited to the following: 25 scale exercise that is 26 or individual, facility-based 27 erindividual, facility-based 28 erindividual, facility-based 29 erindividual, facility-based 29 erindividual, facility-based 20 erindividual, facility-based 20 erindividual, facility-based 21 erindividual, facility-based 22 erindividual, facility-based 23 erindividual, facility-based 24 erindividual, facility-based 25 erindividual, facility-based 26 erindividual, facility-based 27 erindividual, facility-based 28 erindividual, facility-based 29 erindividual, facility-based 20 erindividual, facility-based 20 erindividual, facility-based 21 erindividual, facility-based 22 erindividual, facility-based						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VCX021 Facility ID: 003575

If continuation sheet Page 8 of 21

PRINTED: 03/10/2023 FORM APPROVED OMB NO. 0938-039

	ENT OF DEFICIENCIES  N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155726	ľ í	JILDING	NSTRUCTION	(X3) DATE COMPI 02/07		
	PROVIDER OR SUPPLIED		STREET ADDRESS, CITY, STATE, ZIP COD 400 CAYLOR BLVD BLUFFTON, IN 46714					
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	ON BE PRIATE	(X5) COMPLETION DATE	
	led by a facilitator discussion using a clinically-relevant set of problem star messages, or preto challenge an el (iii) Analyze the [f maintain docume exercises, and en the [facility's] emeta [for Hospices at (2) Testing for hothe patient's home conduct exercises plan at least annuthe following:  (i) Participate in a community based (A) When a community based functional (B) If the hospice man-made emergof the emergency exempt from engascale community-facility-based functional exercise of this section is of include, but is not (A) A second full-community-based functional exercise (B) A mock disast	emergency scenario, and a atements, directed pared questions designed mergency plan. acility's] response to and nation of all drills, tabletop nergency events, and revise ergency plan, as needed.  418.113(d):] pspices that provide care in e. The hospice must so to test the emergency events ally. The hospice must do a full-scale exercise that is levery 2 years; or nunity based exercise is not act an individual facility exercise every 2 years; or experiences a natural or plan, the hospital is aging in its next required full based exercise or individual ectional exercise following the gency event. dditional exercise every 2 are year the full-scale or e under paragraph (d)(2)(i) conducted, that may illimited to the following: escale exercise that is lor a facility based e; or						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VCX021 Facility ID: 003575

If continuation sheet

Page 9 of 21

PRINTED: 03/10/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155726		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 02/07/2023				PLETED	
NAME OF I	PROVIDER OR SUPPLIE	R	•		DDRESS, CITY, STATE, ZIP CODYLOR BLVD	•	
RIVER T	ERRACE HEALTH	CARE CENTER			TON, IN 46714		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX	``	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	) BE )PRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCI		DATE
	discussion using	and includes a group					
		emergency scenario, and a					
	set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.  (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not						
	accessible, condu	ıct an annual individual					
	facility-based fund	ctional exercise; or					
		experiences a natural or					
		gency that requires activation					
		plan, the hospice is					
		aging in its next required					
		nity based or facility-based e following the onset of the					
	emergency event						
		dditional annual exercise					
		but is not limited to the					
	following:						
	(A) A second full-	-scale exercise that is					
	community-based	l or a facility based					
	functional exercis						
	(B) A mock disas						
	` '	ercise or workshop led by a					
		udes a group discussion					
	using a narrated,	clinically-relevant irio, and a set of problem					
		ted messages, or prepared					
		ed to challenge an					
	emergency plan.	ou to originary arr					
		nospice's response to and					
		ntation of all drills, tabletop					
	exercises, and emergency events and revise						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VCX021 Facility ID: 003575

If continuation sheet Page 10 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	<del></del>	COMPL	
		155726	B. WI	NG		02/07/	2023
NAME OF F	PROVIDER OR SUPPLIER	·	-		ADDRESS, CITY, STATE, ZIP COD		
					YLOR BLVD		
RIVER T	ERRACE HEALTH	CARE CENTER		BLUFF	ΓΟN, IN 46714		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the hospice's eme	ergency plan, as needed.					
	*IE - " DDET+ 04	144 404/d) Haaritala at					
		41.184(d), Hospitals at					
	§482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must						
		to test the emergency ar. The [PRTF, Hospital,					
	CAH] must do the	- · · · · · · · · · · · · · · · · · · ·					
	-	in annual full-scale exercise					
	that is community-based; or  (A) When a community-based exercise is not accessible, conduct an annual individual,						
		tional exercise; or					
	1	Hospital, CAH] experiences					
		or man-made emergency					
		ation of the emergency					
		s exempt from engaging in					
	its next required fu	ull-scale community based					
	or individual, facili	ty-based functional exercise					
	following the onse	t of the emergency event.					
	(ii) Conduct a	an [additional] annual					
	exercise or and th	at may include, but is not					
	limited to the follow	_					
	1 ' '	scale exercise that is					
	community-based						
	1	tional exercise; or					
	1 ' '	ck disaster drill; or					
		exercise or workshop that					
	1	or and includes a group					
	discussion, using						
		emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er						
		ne [facility's] response to					
	and maintain documentation of all drills,						
		s, and emergency events					
	I =	cility's] emergency plan, as					
	needed.		I				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VCX021 Facility ID: 003575

If continuation sheet Page 11 of 21

PRINTED: 03/10/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES  OF CORRECTION	IDENTIFICATION NUMBER  155726	UILDING	nstruction 	COMPI 02/07	ETED
	PROVIDER OR SUPPLIEF		400 CA	ADDRESS, 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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	conduct exercises plan at least annu organization must (i) Participate in a that is community (A) When a commaccessible, conduction facility-based function of the exercise of the emerical community-based functional exercise of this section is community-based functional exercise of this section is community-based functional exercise of this section is community-based based functional exercise (B) A mock disas (C) A tabletop exeled by a facilitator discussion, using clinically-relevant set of problem star messages, or preto challenge an erecises, and emerical exercises, and emerical exercises.	ACE organization must to to test the emergency ally. The PACE do the following: an annual full-scale exercise abased; or annual individual, stional exercise; or experiences an actual natural ergency that requires mergency plan, the PACE gaging in its next required antity based or individual, stional exercise following the gency event. In additional exercise every the year the full-scale or experience that may include, to the following: ascale exercise that is or individual, a facility exercise; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. PACE's response to and antation of all drills, tabletop mergency events and revise gency plan, as needed.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VCX021 Facility ID: 003575

If continuation sheet Page 12 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155726		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 02/07/2023			PLETED				
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	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE			
	to test the emerge year, including un the emergency properties of the community (A) When a community (A) When a community (B) If the [LTC fact actual natural or requires activation LTC facility is exerequired a full-scalindividual, facility-following the onse (ii) Conduct an actual may include, following:  (A) A second full-community-based based functional (B) A mock disas (C) A tabletop exiled by a facilitator discussion, using clinically-relevant set of problem stamessages, or preto challenge an ere (iii) Analyze the [I response to and nall drills, tabletop of the community com	an annual full-scale exercise a-based; or aunity-based exercise is not act an annual individual, ational exercise. ility] facility experiences an ann-made emergency that a of the emergency plan, the ampt from engaging its next alle community-based or based functional exercise at of the emergency event. additional annual exercise but is not limited to the ascale exercise that is or an individual, facility exercise; or a recise or workshop that is includes a group a narrated, emergency scenario, and a attements, directed pared questions designed mergency plan. and a trements of the community is an annual exercise and emergency and a trements, directed pared questions designed mergency plan. and a trements of the community is an annual individual, facility's an annual full-scale exercise and emergency and a trements of the community is an annual individual, and annual exercise and exercise and emergency and annual exercise and emergency and annual exercise and emergency annual individual, annual individual, annual exercise and exercise and exercise and emergency annual individual, annual exercise annual individual, annual exercise annual exercise annual individual, annual exercise a							
	(2) Testing. The I	CF/IID must conduct he emergency plan at least							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VCX021 Facility ID: 003575

If continuation sheet Page 13 of 21

PRINTED: 03/10/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155726			UILDING	NSTRUCTION	COMP	E SURVEY LETED 7/2023		
NAME OF PROVIDER OR SUPPLIER RIVER TERRACE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 400 CAYLOR BLVD BLUFFTON, 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 CORRECT! (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON DBE DPRIATE	(X5) COMPLETION DATE	
	twice per year. The following:  (i) Participate in a sthat is community (A) When a community (A) When a community-based function of the eliance of the emerical community-based function of the emerical	n annual full-scale exercise -based; or nunity-based exercise is not not an annual individual, stional exercise; or. experiences an actual ade emergency that requires mergency plan, the ICF/IID agaging in its next required nity-based or individual, stional exercise following the agency event. ditional annual exercise but is not limited to the scale exercise that is or an individual, stional exercise; or er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a attements, directed pared questions designed mergency plan. DF/IID's response to and antation of all drills, tabletop mergency events, and revise regency plan, as needed.  84.102] the HHA must conduct the emergency plan at the HHA must do the full-scale exercise that is						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VCX021 Facility ID: 003575

If continuation sheet Page 14 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155726		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/07/2023					
	PROVIDER OR SUPPLIER		400 CA	STREET ADDRESS, CITY, STATE, ZIP COD 400 CAYLOR BLVD BLUFFTON, 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 B CROSS-REFERENCED TO THE APPROPI	E COMPLETION				
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE				
	` '	ommunity-based exercise							
		conduct an annual							
	every 2 years; or.	based functional exercise							
		A experiences an actual							
	, ,	ade emergency that requires							
		mergency plan, the HHA is							
		iging in its next required							
		ity-based or individual,							
	facility based func	tional exercise following the							
	onset of the emer	gency event.							
	(ii) Conduct an ad	ditional exercise every 2							
		e year the full-scale or							
		e under paragraph (d)(2)(i)							
	of this section is c	•							
		limited to the following:							
	, ,	full-scale exercise that is							
	community-based								
	facility-based fund								
	, ,	saster drill; or							
		exercise or workshop that							
	-	or and includes a group							
	discussion, using	a narrated, emergency scenario, and a							
	set of problem sta	- ·							
	-	pared questions designed							
	to challenge an er								
	_	HA's response to and							
		ntation of all drills, tabletop							
	exercises, and em	nergency events, and revise							
	the HHA's emerge	ency plan, as needed.							
	*[For OPOs at §48	36.360]							
	-	e OPO must conduct							
		he emergency plan. The							
	OPO must do the								
	(i) Conduct a pape	er-based, tabletop exercise							
	or workshop at lea	ast annually. A tabletop							
	-	a facilitator and includes a							
	group discussion,	using a narrated, clinically							

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155726		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV  A. BUILDING COMPLETED  B. WING 02/07/2023			ETED		
100720			B. W.		_	02/07/	2023
	PROVIDER OR SUPPLIER			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 PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	relevant emergency problem statement prepared question emergency plan. If actual natural or not requires activation OPO is exempt from required testing extra of the emergency (ii) Analyze the Office maintain document exercises, and emit the [RNHCl's and needed.  *[ RNCHIs at §403 (d)(2) Testing. The exercises to test the RNHCl must do the control of the exempt of the exercises to test the received designed to challed (ii) Analyze the RN maintain document exercises, and emit the RNHCl's emergated on record reversible facility failed analytic maintain completed requirement. The L'following:	cy scenario, and a set of ts, directed messages, or as designed to challenge an if the OPO experiences an man-made emergency that a of the emergency plan, the om engaging in its next vercise following the onset event. PO's response to and matation of all tabletop mergency events, and revise OPO's] emergency plan, as  3.748]: RNHCI must conduct the emergency plan. The me following: er-based, tabletop exercise A tabletop exercise is a med by a facilitator, using a terelevant emergency et of problem statements, as, or prepared questions enge an emergency plan. WHCI's response to and matation of all tabletop mergency events, and revise regency plan, as needed. The facility's response to and documentation for the fists drill TC facility must do the	E 0	039	E039 It is the facility policy to test emergency plan at least annually. This will be completed with either a full	the	03/03/2023
	is community-based a. When a commun	ity-based exercise is not an annual individual,			scale community based exercise, mock disaster drill a tabletop exercise. The test will be evaluated and analyze to determine needed		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $VCX021 \hspace{0.5cm} \textit{Facility ID:} \hspace{0.5cm} 003575 \hspace{0.5cm} \textit{If continuation sheet} \hspace{0.5cm} \textit{Page 16 of 21}$ 

PRINTED: 03/10/2023 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES	OMB NO. 0938-0				IB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	JILDING	<del></del>	COMPI	LETED		
155726		B. Wl	NG		02/07	/2023		
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	8			AYLOR BLVD			
RIVER T	ERRACE HEALTH	CARE CENTER			TON, IN 46714			
(V4) ID	CUMMARY	CTATEMENT OF DEFICIENCIE	1	ID	<u> </u>		(7/5)	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE	
		ty experiences an actual natural			adjustments for improvemen	ıt.		
	1	gency that requires activation				_		
		lan, the LTC facility is exempt			The corrective action taken	tor		
		ext required full-scale in a			those residents found to be			
	1	or individual, facility-based			affected by the deficient practice	ctice		
		l exercise for 1 year following			include:			
	the onset of the actu				l			
		itional exercise that may			No residents identified.			
	· ·	imited to the following:						
	a. A second full-sca				Other residents that have th			
	1	or an individual, facility-based			potential to be affected have			
	functional exercise.				been identified by:			
	b. A mock disaster				1			
	_	ise or workshop that is led by a			Potentially all residents cou			
		ides a group discussion, using			be affected.			
		y-relevant emergency scenario,			The	_		
		n statements, directed			The measures or systematic			
	challenge an emerg	red questions designed to			changes that have been put	into		
		FC facility's response to and			place to ensure that the			
	· · ·	ation of all drills, tabletop			deficient practice does not re	ecur		
		gency events, and revise the			include:			
	· ·	gency plan, as needed in			The Administrator is			
		CFR 483.73(d)(2). This			The Administrator is			
		ould affect all occupants.			responsible for assuring the			
	deficient practice co	outd affect aff occupants.			EPP is properly tested for	ion		
	Findings include:				improvement and identificati of needed changes. An	IOII		
	rindings include.				exercise to test the			
	Rased on records re	eview with the Administrator			preparedness for an			
		virector on 02/07/23 at 10:41			emergency will be conducted	Ч		
		umentation of an actual			annually and include analysi			
	emergency event or				of the facility's response to	3		
		not show if the facility's			ensure the EPP policies			
		zed to ensure the EPP policies			were effective. A tabletop			
		ed on interview at the time of			exercise will be completed a	nd		
		Administrator and the			a full scale community	iiu		
		tor stated no documentation			exercise is scheduled with the	10		
					Bluffton Fire Department on	16		
for analyzing the LTC facility's response was			1		Pidition Fire Department on		I	

FORM CMS-2567(02-99) Previous Versions Obsolete

completed.

Event ID:

VCX021

Facility ID: 003575

April 20, 2023. The corrective action taken to monitor

If continuation sheet

Page 17 of 21

PRINTED: 03/10/2023 FORM APPROVED 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		(X3) DATE SURVEY COMPLETED 02/07/2023		
	PROVIDER OR SUPPLIER ERRACE HEALTH CARE CENTER	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 APPROPRIA DEFICIENCY)	5.112		
	The finding was reviewed with the Administrator and the Maintenance Director during the exit conference.		performance to assure compli through quality assurance is:			
			The exercise to test the EPF will be presented to QAPI at least annually. Test or actua emergencies will include analysis to evaluate the effectiveness of the respons Findings will be presented in QAPI quarterly.  The date the systemic chan will be completed.  March 3, 2023	e. 1		
K 0000						
Bldg. 01	A Life Safety Code Recertification (LSC) and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).  Survey Date: 02/07/23  Facility Number: 003575 Provider Number: 155726 AIM Number: 200395060  At this LSC survey, River Terrace Healthcare Center was found in substantial compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101,	K 0000				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VCX021

Facility ID: 003575

If continuation sheet

Page 18 of 21

PRINTED: 03/10/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155726		ľ	JILDING	nstruction  01	(X3) DATE COMPL 02/07/	ETED	
NAME OF PROVIDER OR SUPPLIER RIVER TERRACE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 400 CAYLOR BLVD BLUFFTON, IN 46714				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION 10 IAC 16.2.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
K 0353 SS=F Bldg. 01	This one-story facil Type V (111) const sprinklered. The fa with smoke detection to the corridors and the resident rooms. 30 and had a census survey.  All areas where the access were sprinkl maintenance buildin including maintenance sprinklered.  Quality Review core NFPA 101 Sprinkler System Automatic sprinkle are inspected, test accordance with N Inspection, Testin Water-based Fire Records of system inspection and test secure location ar a) Date sprinkler  b) Who provided  c) Water system  Provide in REMAR	ity was determined to be of ruction and was fully cility has a fire alarm system on in the corridors, areas open hard-wired smoke detectors in The facility has a capacity of s of 29 at the time of this residents have customary ered. The facility has a ang providing facility services nice supplies that was not mpleted on 02/09/23  - Maintenance and Testing er and standpipe systems ted, and maintained in NFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, sting are maintained in and readily available. System last checked  - System test  - Supply source  - RKS information on non-required or partial er system.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VCX021 Facility ID: 003575

If continuation sheet Page 19 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	UILDING	01	COMPLETED		
155726		B. W	ING		02/07/2023		
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	R			YLOR BLVD		
RIVER T	ERRACE HEALTH	CARE CENTER			TON, IN 46714		
TAIVEIT		Office Ocivient		DEG! !	1014, 114 407 14		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMP	PLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		ATE
		view and interview, the facility	K 0	353	We are requesting a desk revi		3/2023
		he internal pipe inspection			IDR. In addition to the POC pl	ease	
		1 of 1 sprinkler system in			see attached documents.		
		2.3.5.3. NFPA 25, 2011 Edition,			The required 5 year inspection	1	
	_	t as discussed in 14.2.1.1 and			was completed in 2019 and is		
	_	ion of piping and branch line			scheduled again in 2024.		
		conducted every 5 years by			K353		
		connection at the end of one					
	-	ring a sprinkler toward the end			It is the policy of this facility to		
		for the purpose of inspecting			ensure appropriate maintenan	ce	
	_	foreign organic and inorganic			and testing of the automatic		
		eient practice could affect all			sprinkler system.		
	occupants.				<u> </u>		
					The corrective action taken for	•	
	Findings include:			those residents found to be			
	,				affected by the deficient practi	ce	
		view with the Administrator			include:		
		ce Director on 02/07/23 at 10:05					
		sprinkler inspections listed the		There are no specific residen		3	
		spection completion date as			identified.		
		ntation of the results of the					
		etion was not provided for			Other residents that have the		
		nterview at the time of record				ential to be affected have been	
	·	strator and the Maintenance			identified by:		
		internal pipe inspection was he last 5 years but could not			Detection of a side at a could		
	•	the last inspection.			Potentially all residents could	Эе	
	mid the report from	i die iast hispection.			affected.		
	The finding was re	viewed with the Administrator			The management of evertements		
	_	ce Director during the exit			The measures or systematic	uto.	
	conference.	the Director during the exit			changes that have been put in		
	conference.				place to ensure that the deficient practice does not recur include		
	3.1-19(b)				practice does not recui include	·	
	3.1-17(0)				The Administrator or designed	is	
					responsible to ensure all	15	
					maintenance and testing requ	red	
					is performed timely and that		
					records are maintained. Reco	ds	
					will be maintained in the		
					Administrators office and whe	,	
	I		1		I , tarring a discount of the Wile	• 1	

PRINTED: 03/10/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION NUMBER	a. Building <u>01</u>			COMPLETED	
		155726	B. WING			02/07/2023	
			<u> </u>	_	-		
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					YLOR BLVD		
RIVER T	ERRACE HEALTH	CARE CENTER		BLUFF	ΓΟΝ, IN 46714		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	<u> </u>	ID	NDOLUDENIC EV		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
	·				CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	
TAG	·	R LSC IDENTIFYING INFORMATION		TAG	appropriate in the TELS automated system. Our 5 year inspection was performed on August 30, 2019 and is schedi to be done again in August of 2024.  The corrective action taken to monitor performance to assure compliance through quality assurance is  The Administrator or designee report the status of required testing in QAPI at least annual The quality assurance commit will review and adjust the plan needed.  The date the systemic change will be completed.  February 23, 2023	uled will lly. tee as	DATE

Event ID: VCX021 Facility ID: 003575 If continuation sheet Page 21 of 21