STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155726	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Terrace Health Care Center	400 Caylor Blvd Bluffton, IN 46714

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45243 Based on observation, interview, and record review the facility failed to ensure labeling of open date for 1 of 1 carts reviewed. (Resident 29). Findings include: During an observation, on 01/07/25 at 9:38 AM, in the medication room with Qualified Medical Assistant 3 (QMA) and Registered Nurse 2 (RN), Resident 29's insulins were observed in a compartment labeled with his last name. The half full bottle of Humalog in the compartment was not labeled with an open date or any identifying information. RN 2 indicated there was no way to determine when the medication was opened, who it belionged to, and it would be discarded. A Glargine pen was labeled with an open date of 12/3/24. RN 2 indicated insulin is only good for 28 days after being removed from the refrigerator. The pen was 7 days past the 28 day expiration. RN 2 indicated the Glargine pen would be discarded. Resident 29's compartment also had a half full bottle of Lantus insulin without any labeling to indicate resident name or the opened date. RN 2 indicated there was no way to ensure when the medication was opened, who it bleonged to, and indicated the Lantus insulin would be discarded. During an interview, on 01/07/25 at 9:38 AM, QMA 3 indicated all meds were to be labeled with an open date, residents name, room number, and a discard date or expiration date. Resident 29's record review began on 01/06/25 at 11:13 AM. Resident 29's diagnoses included type 2 diabetes mellutis. Resident 29 had a physcian order for Humalog Humalog Kwik pen 100 units/ml per sliding scale four times per day. Resident 29 also had a physician order for Glargine pen 100 units/ml, inject 50units once daily, hold for blood sugar less than 120. (continued on next page)

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 29's Medication Administration Record (MAR) for Humalog Kwik pen indicated he received the insulin multiple times a day from January 1- January 7, 2025 after blood sugar checks at 8am, noon, 4pm, and 8pm. Resident 29's MAR for the month of January 2025 indicated he received Glargine insulin daily at 8am. A policy titled, Medication labels, dated 5/21/2018 and reviewed 5/20/2020 was received by the Administrator on 1/7/25 at 12:51PM. The policy indicated .1. The labels are permanently affixed to the outside of the prescription container. If the label does not fit it can be affixed to an outside container or carton, the resident's name, at a minimum, must be maintained directly on the actual product container. 2. Each prescription medication label includes: a. Residents name. b. specific directions for use e. prescriber's name. f. date dispensed. g. quantity of the medication h. expiration date of the medication i. name, address, and telephone number of dispensing pharmacy . 3.1-25(j)(m)(n)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 45243 Based on interview and record review the facility failed to document catheter output for 1 of 1 resident reviewed. (Resident 12) Findings include: Resident 12's record review began on 1/6/25 at 11:35AM, diagnoses included Neurospasmatic bladder. Certified Nursing Assistant (CNA) task charting indicated Resident 12 only had one entry for urinary catheter output on the following dates, times and amounts: 12/14/24 at 9:28PM 1200ml 12/21/24 at 1:59PM 901ml 12/23/24 at 9:59PM 600ml 12/25/24 at 1:59PM 1000ml 12/27/24 at 9:59PM 2001ml 12/28/24 at 9:35PM 1100ml 12/31/24 at 1:59PM 701ml 1/4/25 at 1:59PM 1000ml 1/5/25 at 7:37PM 1500ml 1/6/25 at 1:59PM 1000ml No other entries for each shift was available for review by the time of exit. Resident 12's physician order, dated 5/3/24, indicated to give Lasix 20mg, take 1 tabled in am with a start date of 5/6/24. In an interview, on 1/7/25 at 1:37 PM, the Director of Nursing (DON) indicated the importance of keeping track of urinary output of residents with a catheter ensured the first sign of issues were addressed. The DON indicated it was especially important with Resident 12 due to her use of a diuretic medication Lasix. The DON indicated the expectation was for catheters to be emptied at the end of each shift and during routine catheter care or when bag was half full as necessary. The DON indicated education would be required if there were not at a minimum of 2 entries every day for catheter output. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview, on 1/7/25 at 1:42PM, CNA 4 indicated Resident 12 always required at a minimum one emptying of her catheter bag on each shift she has worked. CNA 4 indicated she did not always have time to document the output and therefore the numbers may be inaccurate at times. A current policy and procedure titled, Output, Measuring and Recording dated as revised October 2010, provided by the Administrator on 1/8/25 at 11:05am indicated .The purpose of this procedure is to accurately determine the amount of urine that a resident excretes in a 24-hour period .Steps in the procedure 7. Carefully observe the level of urine in the graduate. Maintain eye level so that you can see the number reached by the level of urine. 8. Record the amount noted on the output side of intake and output record. 9. Record the time the output was measured. Documentation The following information should be recorded on the bedside intake and output record and/or in the resident's medical record: 1. The date and time the resident's urine was measured and recorded. 3. The amount of output . 3.1-50(a)