STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155630	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLATROCK RIVER LODGE	904 E 11TH ST RUSHVILLE, IN 46173

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: November 12, 13, 14, 17, 18, 19, & 20 2014. Facility number: 001126 Provider number: 155630 AIM number: 200011300 Survey team: Angel Tomlinson, RN, TC Barbara Gray, RN, Diana Sidell, RN, [November 17, 18, 19, & 20, 2014] Leslie Parrett, RN, [November 12, 13, 14, 17, 18, & 19, 2014] Census bed type: SNF/NF: 55 Residential: 9 Total: 64 Census payor type: Medicare: 3 Medicaid: 38 Other: 14 Total: 55 Residential sample: 5 These deficiencies reflect state findings	F000000	Preparation and execution of this plan of correction does not constitute admission or agreement by this facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because the previsions of federal and state law require it. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of residents nor are they of such character as to limit the facility's capacity or render adequate care.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 25, 2014 by Cheryl Fielden, RN.			
F000226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview and record review, the facility failed to follow their abuse policy and procedure to assess a resident after an alleged abuse allegation and report the allegation to the physician for 1 of 3 residents reviewed for abuse. (Resident #69) Findings include: On 11/14/14 at 11:56 a.m., Resident #51 reported to LPN #1 that CNA #2 "threw" Resident #69 down in his dining chair at lunch time and placed a gait belt on him tightly. He indicated he sat with Resident #69 during meals. He indicated CNA #2 became aggravated with Resident #69 because he tried to get up out of his chair all the time. Resident #51 indicated he was not going to eat lunch because the	F000226	iThe facility does follow the abuse policy and procedure to assess a resident after an alleged abuse allegation and report the allegation to the physician. On 11/17/2014, the physician was notified of the alleged abuse and a complete skin and body assessment was completed. All staff will be inserviced on the facility Resident Safe Handling Policy. All licensed nurses and IDT will be inserviced on the Physician Notification/Consultation Parameters. An audit will be completed for all reportables for the last 6 months to insure proper notification and assessments were completed per policy. The Administrator or designee will conduct monthly audits for compliance. Any negative findings will be reported to QAPI committee monthly for 6 months.	12/05/2014

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	incident "upset" him. On 11/14/14 at 12:02 p.m., Resident #69 was observed seated upright in a dining chair at a table in the dining room. He was feeding himself independently and ate 100% of his meal. LPN #1 reported the alleged abuse incident against Resident #69 to the Administrator on 11/14/14 at 12:08 p.m. On 11/14/14 at 12:22 p.m., Resident #69 was observed ambulating from the dining room to his bedroom with the assistance of CNA #3 and the use of a gait belt. He was pleasantly confused and had to be directed in the direction of his bedroom. He was seated in a soft recliner on top of a pad alarm and a thick pressure relieving cushion. He was positioned for comfort and provided his call light. After being positioned in his recliner, Resident #69 was queried if anyone at the facility had ever been mean or rough with him or if anyone had ever tried to harm him. He was queried several times and responded with the following answers: "No, not that I know of. You can ask my wife because she is strictly business. Well I was sitting here thinking and I have had the guys at the shop get a little fussy and I just let them think they are getting their way. My wife can be a little tough."		Completion by 12/5/14 IDR reason: The administrator's immediate investigation revealed the witnessed alleged incident was not abuse. Physician notification and assessment was not necessary.	

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	Resident #69's record was reviewed on 11/17/14 at 2:00 p.m. Diagnoses included but were not limited to, Alzheimer's dementia with behavioral disturbances and bipolar disorder. He scored 3 on his admission Brief Interview for Mental (BIMS) exam dated 8/13/14, indicating he was severely impaired for his skill in daily decision making. On 11/17/14 at 2:40 p.m., the Director of Nursing (DON) said there was no assessment documentation for Resident #69 related to the abuse allegation on 11/14/14. On 11/17/14 at 2:45 p.m., the DON indicated a full body assessment had not been completed on Resident #69 and the physician had not been notified of the allegation of abuse against him. She indicated the family had been notified of the abuse allegation on 11/14/14. She indicated she was going to complete a full body assessment on Resident #69 herself. On 11/17/14 at 2:50 p.m., the Assistant Administrator indicated 2 staff members had witnessed Resident #69 lose his balance at the time of the alleged abuse incident so a full body assessment was not completed. She provided a statement			

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	documented by the Administrator on 11/14/14. The statement indicated Resident #69 was asked if anyone was rough with him at lunch and he stated "no one was rough with me. I would walk off and leave them." On 11/17/14 at 3:17 p.m., the DON indicated she had just notified the physician of the alleged abuse allegation that was reported against Resident #69 on 11/14/14. She indicated she had documented a late entry in the computer the family was notified of the alleged incident on 11/14/14. She provided a "Skin and Body Assessment" for Resident #69 completed on 11/17/14, and signed by her indicating the following: "No current skin issues noted." The Abuse "Policies and Procedures" provided by the Administrator on 11/17/14 at 10:20 a.m., indicated the following: "Procedure for Investigation: a. When appropriate, the Quality Assurance Performance Improvement (QAPI) Manager and/or the supervisor on duty will assess the resident (including the size, location, etc., of any injury), and properly document the date, time, and location of the reported or suspected incident... e. The residents' attending physician, facility medical director, corporate management and family will be			

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	notified as soon as possible...." 3.1-28(a)			
R000000	Flatrock River Lodge was found to be in compliance with 410 16.2-5, in regard to the State Residential Survey.	R000000	Preparation and execution of this plan of correction does not constitute admission or agreement by this facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because the previsions of federal and state law require it. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of residents nor are they of such character as to limit the facility's capacity or render adequate care.	