STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155630		01/14/2016

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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Dates of survey: January 6, 7, 8, 11, 13, and 14, 2016 Facility number: 001126 Provider number: 155630 AIM number: 200011300 Census bed type: SNF/NF: 51 Residential: 9 Total: 60 Census payor type: Medicare: 6 Medicaid: 34 Other: 11 Total: 51 Residential sample: 7 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1 and IAC 16.2-5. Quality review completed by 30576 on	F 0000	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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	January 20, 2016.			
F 0157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or			

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	interested family member. Based on interview and record review the facility failed to notify the physician of blood sugar (glucose) levels above 430 for 1 of 5 residents reviewed for unnecessary medication (Resident #25). Findings include: Review of the record of Resident #25 on 1/11/16 at 10:55 a.m., indicated the resident's diagnoses included, but were not limited to, major depression and insulin dependent diabetes mellitus(IDDM). The physician recapitulation for Resident #25, dated November 2015 indicated the resident was ordered blood sugar check four times a day and novolog insulin three times a day per a sliding scale. The care plan for Resident #25, dated 5/4/15, indicated the resident had potential for hypo/hyperglycemia. The interventions included, but were not limited to, check blood sugars and notify the physician as needed. Review of the Medication Administration Record (MAR) for Resident #25 indicated the following: the resident's blood sugar were 433 on 11/23/15, 471 on 12/31/15, 451 on 12/25/15 and 460 on	F 0157	The facility does notify the physician of blood sugars (glucose) levels above 430. Physician and family were notified 1-26-16 of resident #25's blood sugars greater than 430, no new orders given. An audit of all diabetic residents having blood sugar testing was completed and determined to be in compliance. All licensed nursing staff were reeducated on Physician notification policy for blood sugars monitoring. The DON or designee will monitor 5 random diabetic resident records per week for 8 weeks to ensure continues compliance, any negative findings will reported to QAPI. If after two months of no negative findings the audit will be discontinued.	02/12/2016

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	1/3/16. Interview with the Director Of Nursing (DON) on 1/13/16 at 10:31 a.m., indicated notification of high blood sugars were done per the facility policy unless the physician orders different parameters for notification. Interview with RN #3 on 1/13/16 at 11:40 a.m., unable to find any notification to the physician of Resident #25's high bloods sugars. Interview with the DON on 1/13/16 at 11:50 a.m., indicated she was unable to find where the physician was notified of Resident #25's high blood sugars. The physician notification/ consultation parameters provided by the Director Of Nursing (DON) on 11/13/16 at 10:40 a.m., indicated the physician was to be notified immediately for resident with a blood glucose greater that 430 in diabetic resident using sliding scale insulin. 3.1-5(a)(2) 3.1-5(a)(3)			
F 0272 SS=D Bldg. 00	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and			

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	periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.			
	Based on observation, interview and record review the facility failed to note a Minimum Data Set (MDS) assessment correctly for a resident's dental status for 1 of 4 residents who met the criteria for dental status and services of 3 residents reviewed (Resident#44).	F 0272	The facility does note a Minimum Data Set (MDS) assessment correctly for a resident's dental status. Resident #44's MDS assessment was corrected 1/27/16. The facility MDS Coordinator or designee will review medical records/MDS of all current resident to ensure all	02/12/2016

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	Findings include: During observation on 1/6/16 at 2:32 p.m., Resident #44 had one tooth in his upper mouth and 5 broken and black teeth in his lower mouth. Resident #44 indicated his teeth made it difficult to chew and he would like to see a dentist and get dentures. Review of the record of Resident #44 on 1/8/16 at 1:15 p.m., indicated the resident's diagnoses included, but were not limited to, Parkinson, hypertension, dementia and acute renal failure. The Quarterly MDS assessment for Resident #44, dated 10/27/15, indicated the resident was admitted to the facility on 11/24/14, the resident had did not have marked obvious or likely cavity or broken teeth and did not have marked difficulty chewing. Interview with MDS coordinator #1 on 1/11/16 at 1:55 p.m., indicated the MDS was marked incorrectly for dental status for Resident #44. The MDS coordinator #1 indicated Resident #44 did not have a careplan in place his for dental status because it was not marked correctly on the MDS's.		dental statuses to be documented correctly. MDS Coordinator retrained on proper dental status documentation. The Administrator or designee will review 3 random records to verify dental status accuracy weekly for 3 months, any negative findings will be reported to QAPI committee, after two months of no negative findings the audit will be discontinued.	

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	3.1-31(c)(9)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review the facility failed to follow an physician order to fax the physician with a weeks blood sugar results after an insulin medication change for 1 of 5 residents who met the criteria for unnecessary medication use (Resident #25). Findings include: Review of the record of Resident #25 on 1/11/16 at 10:55 a.m., indicated the resident's diagnoses included, but were not limited to, major depression and insulin dependent diabetes mellitus (IDDM). The physician order for Resident #25, dated 10/4/15 (no time), indicated to increase the resident's evening time lantus to 30 units and report the resident's blood sugars in one week. Interview with the Administrator In	F 0282	The facility does follow a physician order to fax the physician with a weeks blood sugar results after an insulin medication change. Resident #25's physician and family were notified 1/26/16 of October blood sugars results as ordered 10/6/15 following an increase in the residents evening Lantus. An audit of all residents medical records was completed to ensure all notification are documented and in compliance. All licensed nursing staff were reeducated on Physician notification policy for blood sugars notifications. The DON or designee will monitor 5 random diabetic resident records per week for 8 weeks to ensure continued notification compliance any negative findings will be reported to QAPI committee, after two months of no negative findings the audit will be discontinued.	02/12/2016

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	Training (AIT) on 1/13/16 at 2:10 p.m., indicated she was unable to find where the facility faxed a weeks worth of blood sugars to the physician as ordered for Resident #25 in October 2015. Interview with the AIT on 1/13/16 at 3:15 p.m., indicated the facility did not have a policy for following physician orders and that it was standard practice to follow the physician orders. 3.1-35(g)(1)			
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview and record review the facility failed to have the Registered Dietician (RD) provide an assessment and recommendations for a resident with a low Body Mass Index (BMI) for 1 of 8 residents who met the criteria for underweight with no supplements for 3 residents reviewed for nutrition (Resident #64). Finding include:	F 0309	The facility does have the Registered Dietician provide an assessment and recommendations for a resident with a low Body Mass Index (BMI). Resident #64 was assessed by the Registered Dietician 1/8/16, recommendation made to start med pass 2.0 nutritional supplement 90mls two times daily. Resident #64 received new orders 1/12/16 for med pass 90mls two times daily. An audit of current residents medical records was completed	02/12/2016

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	During interview and observation on 1/8/16 at 9:50 a.m., Resident #64 indicated his normal weight had been 160 pounds. The resident indicated he did not have an appetite. Resident #64's family member indicated the resident had times where he would not eat and she was unsure why. The resident was tall with a thin stature. Review of the record of Resident #64 on 1/8/16 at 10:06 a.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer dementia, constipation, hypothyroidism and hypertension. The physician recapitulation for Resident #64, dated January 2016, indicated the resident was ordered a regular diet. The careplan for Resident #64, dated 5/18/15, indicated the resident had potential for weight fluctuation related to dementia Alzheimers. The interventions included, but were not limited to, provide a regular diet, offer fortified cereal at breakfast and honor preferences. The Quarterly Minimum Data Set (MDS) assessment for Resident #64, dated 10/30/15, indicated the resident was admitted to the facility on 5/7/15, he was able to understand others and was able to		to ensure Registered Dietician assessments and recommendations have been completed for all residents with a low Body Mass Index (BMI) and found to be in compliance. The Dietary Manager was retrained on Registered Dietician assessment requirements. The Administer or designee will review 3 random resident records weekly for 8 weeks to ensure Registered Dietician assessments are being completed, any negative findings will be reported to the QAPI committee, after two months of no negative findings the audit will be discontinued.	

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	make himself understood and he was independent with eating requiring set up assistance only for meals. Review of Resident #64's weights indicated the following : 8/10/15- 148 pounds, 9/9/15- 149 pounds, 10/13/15- 148 pounds, 11/27/15- 147 pounds , 12/22/15-154 pounds and 1/13/16 his weight was 145 pounds. Interview with LPN #1 on 1/8/16 at 2:50 p.m., indicated Resident #64 did not have dietary assessment completed by the Registered Dietician (RD). The Registered Dietician assessment for Resident #64, dated 1/8/16 at 6:00 p.m., indicated the resident height was 71.5 inches, his weight was 144 pounds and his Body Mass Index (BMI) was 20.3. The resident's total calorie needs were 2340, protein was 65 grams, total fluids were 1950 cc. The resident's intake meets 76-100% of his nutritional estimated needs. The resident received and tolerated a regular diet and was able to feed himself. It was "noted the resident had a 6.4 pound weight loss" in the past 30 days, "start med pass 2.0 nutritional supplement 90 cc two times a day". Interview with the Dietary Manager on 1/13/15 at 11:00 a.m., indicated when			

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	Resident #64 was admitted the facility had missed having him evaluated by the RD. The Dietary Manager indicated the protocol was the RD came twice a month and done her assessments for residents on admission and annually unless there was a problem she would do the assessments more often such as skin issues, significant change and weight loss. Interview with the Dietary Manager on 1/13/16 at 2:55 p.m., indicated the December 2015 weight for Resident #64 had been an error and his actual weight for December was 148 pounds. Interview with the Administrator on 1/13/16 at 3:39 p.m., indicated it was the responsibility of the Dietary Manager to ensure residents were assessed by the RD on admission, significant change, residents with weight loss and eating problems. 3.1-37(a)			
F 0314 SS=D Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure			

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	sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review, and interview, the facility failed to ensure residents, with a high risk of pressure ulcers, had a pressure relieving device in their chairs, and appropriate interventions. This affected 2 of 3 residents reviewed for pressure ulcers. (Resident #68 and #12) Findings include: Resident #68's record was reviewed on 1/8/16 at 9:24 a.m. Diagnoses, from the current physician's orders dated 1/1/16 to 1/31/16, indicated, but were not limited to; aftercare following joint replacement surgery, pneumonia, atrial fibrillation, high blood pressure, Parkinson's disease, malignant neoplasm of the prostate, dementia, generalized muscle weakness, difficulty swallowing, and history of stroke. An admission Minimum Data Set (MDS) assessment, dated 10/14/15, indicated Resident #68 was severely impaired in cognitive skills for daily decision making, required extensive assistance of two for bed mobility and transfers, did not walk, used a wheel chair, was	F 0314	The facility does ensure resident with a high risk of pressure ulcer, have a pressure relieving device in their chair, and appropriate interventions. Resident #68's had a cushion placed 1/8/16 in his wheelchair with his care plan/assignment sheet updated. Resident #12 was discharged from the facility on 11/17/15. An audit of all medical records completed to ensure all residents at risk for pressure ulcers have interventions in place and documented on the care plan and CNA assignment sheet, and facility in compliance. All licensed nursing staff were re-educated on Skin Care Management Policy requirements. The DON or designee will monitor 5 random resident records weekly for 8 weeks to ensure appropriate interventions, any negative findings will be reported to the QAPI committee, after two months of no negative findings the audit will be discontinued.	02/12/2016

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	admitted with two stage two pressure ulcers, was at risk for developing pressure ulcers, had one unstageable (due to non-removable dressing/device) pressure ulcer present upon admission, three unstageable pressure ulcers with suspected deep tissue injury in evolution that were present upon admission, no venous or arterial ulcers, had a pressure reducing device for his bed, was on a turning and repositioning program, and received pressure ulcer care. A significant change MDS, dated 11/23/15, indicated Resident #68 was severely impaired in cognitive skills for daily decision making, required extensive assist of one for bed mobility, was totally dependent on two of staff for transfers, did not walk, used a wheel chair, was at risk for pressure ulcer development, had two stage three pressure ulcers, had two unstageable pressure ulcers with suspected deep tissue injury in evolution, had healed pressure ulcers since the prior assessment, had no venous or arterial ulcers, had a pressure reducing device for his bed, was on a turning and repositioning program, and received pressure ulcer care. A Braden scale skin assessment, dated 11/23/15, indicated: "Mobility: Very limited - makes occ.(occasional) slight			

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	changes in body/extremity position - can't make freq (frequent) /signif (significant) changes alone. Friction/shear: Potential problem - Moves w (with) /min (minimal) assist. Some sliding w/occ. slides down in bed/chair. Activity: Chairfast - ability to walk severely limited/none. Can't bear wt. (weight) &/or assisted to chair or w/c (wheelchair). Moisture: Very moist - Skin is often, but not always moist. Linen must be changed at least once per shift. Nutrition: Adequate - Eats > (greater than) 1/2 of most meals. Eats 4 protein/day. Occ. refuses a meal, usually takes supplement. Sensory perception: No impairment - Responds to verbal commands - No sensory deficit limiting ability to feel/voice pain/discomfort." A care plan, dated 11/23/15, indicated: "Problem: Tissue integrity impairment, related to decreased mobility, manifested by: resident has pressure areas to right and left great toe, right ankle and top of right foot and right heel. Approach: Nurses - Assess skin status, assess nutrition...follow medical plan for treatment, monitor all current skin issues for redness, warmth, or drainage...Nurse Aide - Keep skin clean and dry...Encourage and assist to reposition, elevate resident's heels off of bed, inspect skin q. (every) shift...Air mattress on bed.			

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	Report Changes, keep nurse updated on changes/concerns...Transfer assist: Assist of 2 (brand name of lift), large sling, (name of specialty chair) when up, enabler on bed...air mattress on bed...." During an observation on 1/6/16 at 11:39 a.m., Resident #68 was up in his specialty chair and was taken out of his room. No pressure reducing device was observed on his chair. On 1/8/16 at 11:45 a.m., Resident #68 was observed as CNA #4 and an unknown CNA transferred the resident, using a mechanical lift, from the bed to a specialty chair with wheels and a high back. There was no pressure reducing pad on the specialty chair. During an Interview, on 1/8/16 at 2:14 p.m., LPN #1 indicated the pressure areas on his toes, heel, and ankle were caused by the TED (compression) hose he wore at the hospital; they aren't sure how it came back (how he developed a blister) - he had a pressure relieving mattress, heel boots, and heels are floated and the area came back. During an interview, on 1/8/16 at 2:49 p.m., LPN #1 indicated Resident #68 did not have a cushion in his chair other than the cushion on the chair.			

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	During an observation, on 01/13/16 at 10:08 a.m., with CNA # 4 and CNA #5, and the DoN present, Resident #68 was given incontinence care. The skin on Resident #68's groin and buttocks was clear, and the skin around the coccyx area was reddened with no open areas. 2. Resident #12's record was reviewed on 1/8/16 at 2:23 p.m. She was admitted to the facility on 10/12/15. Her diagnoses documented on her October 2015 physician recapitulation orders indicated but were not limited to hypertension, hypothyroidism, and debility. A Skin and Body Assessment for Resident #12 dated 10/12/15, documented on a human figure, indicated she had a purple area on her left buttock and a red area on her coccyx. No measurements were documented related to the discolored areas. A Skin Care Flow Sheet for Resident #12 initiated 10/21/15, indicated she had a stage I pressure area on her coccyx not present on admission. The area measured 11 centimeters (cm) by 9 cm. The edges were well defined with her skin fully intact and purple in color. Her treatment was Calmoseptine. A physician's order for Resident #12			

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	documented on her October 2015 physician orders initiated 10/23/15, indicated the following: "Apply Calmoseptine to coccyx three times a day and PRN (as needed) until healed NOC (night) AM PM and as needed." A Tissue Tolerance Protocol for Resident #12 dated 10/23/15, indicated she had a skin pressure area on her coccyx. She would be repositioned approximately every hour. She had a pressure relieving mattress on her bed. Resident #12's significant change Minimum Data Set (MDS) assessment dated 10/26/15, indicated she was understood and she usually had the ability to understand others. She was cognitively intact in her daily decision making skills. She required extensive assistance of 1 person for bed mobility, transfer, dressing, toileting, and personal hygiene. She utilized a walker and wheelchair for mobility devices. She required limited assistance of 1 to ambulate in her room. She was occasionally incontinent of urine. She was at risk for pressure ulcers and had 1 unhealed stage I pressure ulcer not present on her prior assessment. She utilized a pressure relieving device on her bed. She received pressure ulcer care and an application of ointment to her pressure			

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	area. She was on a turning and repositioning program. A Care Plan for Resident #12 initiated 10/29/15, indicated the following: "Problem: Tissue Integrity Impairment, related to: decreased mobility, occasional urinary incontinence. Manifested by: stage I pressure ulcer to coccyx. Goal: Stage 1 area to coccyx will decrease in size by goal date. Approach: Nurses - Assess nutrition stat. Administer treatments per MD order. If new skin issues arises notify MD and request treatment per facility protocol. Keep resident in turning program to avoid skin issues. Keep family and physician informed of changes. Nurse Aide - Keep skin clean and dry. Use assist PRN to help reposition in bed, to avoid friction, use lift sheet PRN. Report any new redness or changes to your nurse. Encourage her to go to the activity room when activities are scheduled. Encourage resident to be up in wheelchair at times throughout the day. Encourage consumption of all foods and fluids served. Pressure relieving mattress." An interview with the Administrator in training (AIT) on 1/13/16 at 2:12 p.m., indicated Resident #12 had no skin issues from her admission on 10/12/15 through 10/20/15. Resident #12 developed a			

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	stage I pressure ulcer on 10/21/15. Resident #12 received a physician's order for Calmoseptine on 10/23/15. An interview with the AIT on 1/13/16 at 3:18 p.m., indicated she was unable to locate any documentation Resident #12 utilized a pressure relieving device in her wheelchair. The facility was unable to provide any documentation Resident #12 received any treatment to the purple area on her left buttock or the red area on her coccyx that was present on her admission 10/12/15, until a stage I coccyx pressure ulcer was documented on 10/21/15. A Policy and Procedure for "Persons at Risk" with a last review date of 8/15, was provided by the administrator on 1/11/16 at 10:30 a.m. The policy included, but was not limited to: "Purpose: It is the policy of this facility to proactively and holistically address the status of residents who are considered to be at risk....h. Pressure Ulcers/Stasis Ulcers i. Definition of PAR residents 1. Residents with pressure sore areas of Stage 2 or greater. 2. Residents with open lesions or sores, other than pressure ulcers, such as stasis or diabetic ulcers...9. Develop interventions, consider all possible consequences of skin breakdown and care			

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	plan for prevention of associated problems (i.e., infection, pain, limited mobility, decreased ADL's, social isolation, depression, etc.)...." 3.1-40(a)(1) 3.1-40(a)(2)			
F 0353 SS=E Bldg. 00	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on interview and record review, the facility failed to ensure adequate staffing to provide for the needs of the residents. This deficient practice has the	F 0353	The A.I.T to review the past fifteen (15) days staffing to assure the facility had sufficient nursing staff to provide nursing and related services to attain or maintain the highest practical physical, mental, and	02/12/2016

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	potential to affect all 60 residents in the facility. (Resident #20, Resident #32, Resident #48, Resident #53, Resident #54, Resident #57, and Resident #68). Findings include: 1. During an interview on 1/6/16 at 1:37 p.m., Resident #20's family member indicated there wasn't enough staff available in this facility to make sure that residents get the care and assistance they need without having to wait a long time. The family member indicated that part of the time, they don't have enough staff, especially on the weekends. One time recently, her family member didn't get put to bed and said she stays with her until she goes to bed at night, then she leaves. Resident #20's record was reviewed on 1/14/2016 at 9:03 a.m. The current physician's orders, dated 1/1/16 through 1/31/16, indicated diagnoses that included, but were not limited to: end stage cardiac disease, heart disease, chronic pain, chronic obstructive pulmonary disorder, and iodine deficiency related thyroid disorders. A quarterly Minimum Data Set (MDS) assessment, dated 10/15/16, indicated Resident #20 was moderately impaired in		psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The audit revealed that these services were being met when considering time management, daily assignments and resident acuity. In-servicing and education will be completed by 1/26/16 ,to address the importance and policy expectations of meeting resident care needs to include the time management of; bathing/showers, turning and repositioning, incontinence care and any other reasonable care needs the resident may have. The DON or designee will review daily staffing sheets to ensure enough staffing is scheduled to meet the care needs of each resident. Social Service or designee will meet with residents and/or resident responsible parties three (3) times a week for 90 days and on-going to identify any resident care/staffing concerns. Any negative findings will be reported to the QAPI committee.	

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	cognitive skills for daily decision making; decisions poor, cues/supervision required, needed extensive assistance of two for bed mobility, transfers, toileting, required extensive assistance of one for dressing, eating, personal hygiene, was frequently incontinent of urine, and used a wheelchair. 2. During an interview, on 2/6/16 at 1:42 p.m., Resident #32 indicated all shifts are short staffed but mostly at night she has seen residents begging for things. The resident said she is independent. Resident #32's record was reviewed on 1/14/16 at 8:53 a.m. Current physician's orders, dated 1/1/16 through 1/31/16, indicated diagnoses that included, but were not limited to: acute kidney failure, high blood fats, rheumatoid arthritis, iron deficiency anemia, vitamin B 12 deficiency, constipation, right shoulder fracture/dislocation, diabetes mellitus, high blood pressure, Alzheimer's dementia, and chronic pain syndrome. A significant change MDS, dated 12/17/15, indicated Resident #32 was cognitively intact, required limited assistance of one for dressing, toileting, personal hygiene, bathing, had impairment on one side for range of motion, was frequently incontinent of			

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	urine, and used a wheelchair. 3. During an interview, on 1/6/16 at 11:14 a.m., Resident #48 indicated there is not enough staff, and that it "Seems like forever sometimes when I put call light on to go to the bathroom. I'm supposed to have someone with me to keep from falling. Sometimes I wait and wait and wait and look down the hall to see if I see staff. One time I went by myself and I got the devil for it. Sometimes I wait 30 minutes or so." Resident #48's record was reviewed on 1/14/16 at 8:58 a.m. Current physician's orders, dated 1/1/16 through 1/31/16, indicated diagnoses that included, but were not limited to: high blood pressure, edema, osteoporosis, high blood fats, and low blood potassium levels. A quarterly MDS, dated 11/17/15 indicated Resident #48 was moderately impaired in cognitively skills for daily decision making, required extensive assist of one for bed mobility, transfers, walking, dressing, toileting, bathing, and personal hygiene, and used a walker and wheelchair. 4. During an interview, on 1/6/16, at 2:38 p.m., Resident #53 indicated: "We don't have enough girls on the floor.			

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	Don't have enough in the daytime, evening or night time. It's really sad." Resident #53's record was reviewed on 1/14/16 at 9:00 a.m. Current physician's records, dated 1/1/16 through 1/31/16, indicated diagnoses that included, but were not limited to: left hip fracture, high blood pressure, osteoarthritis, neuropathy of legs, anxiety, anemia, gastro esophageal reflux disorder, depression, asthma, chronic obstructive pulmonary disorder, chronic pain, and diverticulosis of the small intestine. A quarterly MDS, dated 11/5/15, indicated Resident #53 was cognitively intact, required set up from staff for activities of daily living, and one person assist with bathing and personal hygiene, and used a walker or wheelchair. 5. During an interview, on 1/7/15 at 10:20 a.m., Resident #54 indicated they did not have enough staff available and said: "Well we usually have to wait a long time, half hour to an hour. If they are busy we just have to wait." She indicated she waited about 15-20 minutes this morning to be cleaned up after she had a bowel movement and she knew when she had to have a bowel movement and could used a bed pan. She indicated: They came in after I had already messed			

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	my pants." Resident #54's record was reviewed on 1/11/16 at 2:40 p.m. Current physician's orders, dated 1/1/16 through 1/31/16, indicated Resident #54 had diagnoses that included, but were not limited to, history of left hip fracture with repair, congestive heart failure, chronic obstructive pulmonary disorder, Parkinson's disease, anxiety, osteoporosis, and high blood pressure. A quarterly MDS, dated 10/13/15, indicated Resident #54 was moderately impaired in cognitive skills for daily decision making, required extensive assist of two for transfers and toileting, did not walk, and was frequently incontinent of urine. 6. During an interview on 1/7/16 at 11:01 a.m., Resident #57 indicated sometimes there is not enough staff, if she turns on her call light, it would take 15 minutes or longer, then staff comes in, turns off the call light and says they will be right back but they never return. She indicated this happens on all shifts. Resident #57's record was reviewed on 1/14/16 at 9:05 a.m. Physician's orders dated 1/1/16 through 1/31/16, indicated Resident #57 had diagnoses that			

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	included, but were not limited to: compression fracture of a lumbar vertebra, high blood pressure, constipation, lower extremity edema, peripheral neuropathy, presenile dementia, generalized osteoarthritis, major depressive disorder, generalized anxiety disorder, insomnia, and osteoarthritis. A quarterly MDS, dated 11/12/15, indicated Resident #57 was moderately impaired in cognitive skills for daily decision making, required extensive assistance of one for bed mobility, personal hygiene, bathing, toilet use, dressing, walking in room, required extensive assistance of two for transfers, was frequently incontinent of bladder, and occasionally incontinent of bowel, and used a walker or wheelchair. 7. During an interview, on 1/6/16 at 2:27 p.m., Resident #68's family member indicated there was not enough staff available: sometimes he sits up in his chair for a long time, and staff doesn't get to him very timely. She indicated he shouldn't have to sit up so long, and there isn't enough staff in the dining room to feed the residents timely, sometimes breakfast lasts until 9 or 10 o'clock. Resident #68's record was reviewed on			

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	1/8/16 at 9:24 a.m. Diagnoses, from the current physician's orders dated 1/1/16 to 1/31/16, indicated, but were not limited to; aftercare following joint replacement surgery, pneumonia, atrial fibrillation, high blood pressure, Parkinson's disease, malignant neoplasm of the prostate, dementia, generalized muscle weakness, difficulty swallowing, and history of stroke. An admission Minimum Data Set (MDS) assessment, dated 10/14/15, indicated Resident #68 was severely impaired in cognitive skills for daily decision making, required extensive assistance of two for bed mobility and transfers, did not walk, used a wheel chair, was admitted with two stage two pressure ulcers, was at risk for developing pressure ulcers, had one unstageable (due to non-removable dressing/device) pressure ulcer present upon admission, three unstageable pressure ulcers with suspected deep tissue injury in evolution that were present upon admission, no venous or arterial ulcers, had a pressure reducing device for his bed, was on a turning and repositioning program, and received pressure ulcer care. During an interview, on 1/13/16 at 1:35 p.m., the Director of Nurses indicated the guideline she goes by is one staff to ten			

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	residents during the day when they are up and most active, sometimes staffs more due to showers and residents who require us of a mechanical lift. She staffs fewer staff for second shift because residents go to bed on second shift and also staffs fewer on night shift. They have not been told how many they can or can't staff. Staffs heavier on shower days so they don't have to take staff off the floor. 3.1-17(a) 3.1-17(b)			
F 0412 SS=D Bldg. 00	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on observation, interview and record review the facility failed to provide a resident with an oral surgeon for a resident with broke, black and	F 0412	The facility does provide a resident with an oral surgeon for a resident with broke, black and missing teeth and who desired to have dentures. Resident #44	02/12/2016

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	missing teeth and who desired to have dentures for 1 of 4 residents who met the criteria for dental status and services of 3 residents reviewed for dental status (Resident #44). Finding include: During observation and interview with Resident #44 on 1/6/16 at 2:32 p.m., Resident #44 had one tooth in his upper mouth and 5 broken and black teeth in his lower mouth. Resident #44 indicated his teeth made it difficult to chew his food and he would like to see a dentist and get dentures. Review of the record of Resident #44 on 1/8/16 at 1:15 p.m., indicated the resident's diagnoses included, but were not limited to, Parkinson, hypertension, dementia, acute renal failure, hypothyroidism and vitamin B 12 deficiency. The dental referral made by the Dentist for Resident #44, dated 2/3/15, indicated the resident was referred to an oral surgeon for extraction of 5 teeth per the resident's request. The physician order for Resident #44, dated 6/11/15, indicated the resident was ordered an upgrade in diet to mechanical		stated he does not have any current chewing or swallowing issues at present. Denies pain and discomfort and he and family undecided if they would like referred to oral surgeon. An audit of all medical records of current residents completed to ensure all resident needing referred to dentist or oral surgeon have been completed. All licensed nursing staff were reeducated on the Dental Service Policy. The DON or designee will review 5 random resident records monthly for 12 weeks to ensure continued compliance, any negative findings will be reported to the QAPI committee, after two months of no negative findings the audit will be discontinued.	

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FLATROCK RIVER LODGE	904 E 11TH ST RUSHVILLE, IN 46173

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	soft with thin liquids. The dental exam completed by the dentist for Resident #44, dated 9/11/15, indicated the resident had gross decay on remaining teeth and poor oral hygiene. The Quarterly Minimum Data (MDS) assessment for Resident #44, dated 10/27/15, indicated the resident was admitted to the facility on 11/24/14, the resident did not have marked obvious or likely cavity or broken teeth and did not have marked difficulty chewing. Interview with LPN #1 on 1/8/16 at 1:55 p.m., indicated Resident #44 had not had an oral assessment completed by nursing staff. LPN #1 indicated the oral assessments were to be completed on admission and quarterly. Interview with LPN #1 on 1/8/16 at 2:30 p.m., indicated Resident #44 had not seen the oral surgeon. LPN #1 indicated the nurse who was caring for the resident during that time was no longer employed at the facility and she was unsure why the resident did not get seen by the oral surgeon. During observation and interview on 1/8/16 at 2:40 p.m., LPN #1 did an oral assessment on Resident #44, the resident			

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	had 5 broken and black teeth on the bottom and one tooth on the top. The resident indicated it made it hard to chew his food with his teeth and he wanted dentures. Interview with MDS coordinator #1 on 1/11/16 at 1:55 p.m., MDS's were marked incorrectly for Resident #44 dental status and he did not have a careplan for dental status because it was not marked correctly on the resident's MDS's. Interview with Resident #44's family member on 1/11/16 at 1:55 p.m., indicated the resident complained about his meat being ground up and wanted to eat regular food. The brief oral health status examination assessment tool for Resident #44, dated 1/8/16, indicated the resident had problematic symptoms of redness at border around 1-6 teeth and significant problematic symptom of 4 or more decayed or broken teeth/roots, fewer than 4 teeth in either jaw and 0-7 pairs of teeth in either jaw. The resident requested to see a dentist. Interview with the Administrator In Training (AIT) on 1/13/16 at 3:39 p.m., indicated nursing was responsible to follow through when the dentist had			

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	made a referral for an oral surgeon. 3.1-24(b)			
R 0000 Bldg. 00	These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.	R 0000	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.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall			

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	depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. This state residential rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure that staff working on the residential care unit had current first aid training. Findings included: Employee personnel files were reviewed on 1/14/16 at 10:30 a.m. and indicated no staff had first aid training. There are currently ten residents residing on the residential unit. During an interview, on 1/1/4/16 at at	R 0117	The facility does ensure that staff working on the residential care unit have current first aid training. The DON or designee will ensure that the monthly schedule includes and denotes at least one awake staff member on each shift with first aid certification. All nursing staff and managers will be educated on the need to ensure that an employee with current first aid certification is used for a replacement for a call off of the denoted first aid employee if a call-in occurs. The facility does staff licensed nurses with CPR/First Aid certification 24 hours a day 7 days a week.	02/12/2016

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	1:08 p.m., the Administer in Training indicated "All of our nurses are CPR certified but they haven't had the first aid training.			
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on interview and record review the facility failed to assess a resident for self administration of eye drops for 1 of 7 residents reviewed for self medication administration. (Resident #8) Findings include: Resident #8's record was reviewed on 1/14/16 at 1:00 p.m. Her diagnosis documented on her January 2016 physician recapitulation orders indicated she had macular degeneration.	R 0216	The facility does assess a resident for self-administration of eye drops reviewed for self-medication administration. Resident #8 was assessed 1/14/16 and was determined to be safe to self-administer her eye drop. An audit of all current resident administering self-medication completed and in compliance. The Administer will randomly audit 5 resident records per month for 3 months to ensure continued compliance any negative findings will be reported to the QAPI	02/12/2016

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	Resident #8's January 2016 physician recapitulation orders indicated the following order initiated on 12/11/12: "(Systane Ultra) Polyethyl Glycol-Propyl Glycol 8.4%-0.3% Solution dose ordered: (2 drop) to eye(s) (both) three times a day 0800 1200 1700 FOR: Macular Degeneration Administration Instructions: MAY KEEP AT BEDSIDE." On 1/14/16 at 1:30 p.m., LPN #1 indicated Resident #8 administered her own eye drops. No self medication administration assessment was available in Resident #8's record. On 1/14/16 at 2:07 p.m., the Administrator in Training (AIT) indicated Resident #8 had not had a self medication administration assessment and herself and LPN #1 had just completed one. The AIT indicated Resident #8 was able to tell her and LPN #1 what the eye drops were for and how frequently she needed to administer them. Resident #8 had also demonstrated to AIT and LPN #1 the proper technique for self administering the eye drops. On 1/14/16 a 2:24 p.m., the AIT indicated the facility did not have a self		committee.	

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	medication administration assessment form. She indicated there was no policy for self medication administration. She indicated Resident #8 was alert to person and staff.			