

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 08/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FLATROCK RIVER LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>This visit was for the Investigation of Complaint IN00155213</p> <p>Complaint IN00155213 - Substantiated. Federal and state deficiency related to the allegations is cited at F159.</p> <p>Survey dates: August 28 and 29, 2014</p> <p>Facility number: 001126 Provider number: 155630 AIM number: 20011300</p> <p>Survey team: Penny Marlatt, RN, TC</p> <p>Census bed type: SNF/NF: 55 Residential: 9 Total: 64</p> <p>Census payor type: Medicare: 4 Medicaid: 43 Other: 17 Total: 64</p> <p>Sample: 3</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000		
---------	--	---------	--	--

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

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 08/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FLATROCK RIVER LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
F000159 SS=E	<p>Quality review completed on Septmeber 3, 2014 by Cheryl Fielden, RN.</p> <p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p>			

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 08/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FLATROCK RIVER LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on interview and record review, the facility failed to ensure 2 of 3 residents reviewed for personal funds in a sample of 3 had written authorization from the resident and/or family to hold, safeguard, manage and account for the resident's personal funds. Additionally, the facility failed to ensure generally accepted accounting principles were utilized for 1 of 3 residents in a sample of 3 reviewed for personal funds. These deficient practices had the potential to adversely affect the accuracy of any funds held by the resident. (Resident #A and #B)</p> <p>Findings include:</p> <p>1. a. Resident #A's clinical record was reviewed on 8-28-14 at 11:15 a.m. Her diagnoses included, but were not limited</p>	F000159	<p>The written authorization has been obtained by the facility to manage resident trust accounts for the two residents mentioned in the survey. The facility will complete an audit of all residents who have a resident trust account with the facility to ensure written authorization is in place for the facility to manage a resident trust account. Business Office Manager and Business Office Assistant will be in-serviced on the principles and practice of generally Accepted accounting Principles. The resident trust accounts will be audited quarterly for compliance. The BOM and BOA will report findings to the QAPI Committee quarterly. The administrator will be responsible to ensure the above POC is met with compliance.</p>	09/28/2014

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 08/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FLATROCK RIVER LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>to, congestive heart failure, general weakness and neurotic depression. It indicated she was admitted to the facility 3-27-2009. In review of her most recent Minimum Data Set assessment, dated 8-11-14, it indicated resident #A was severely cognitively impaired.</p> <p>In interview with the Executive Director (ED) on 8-29-14 at 10:30 a.m., she indicated the resident's family had elected to open a patient trust account upon admission. She indicated this would allow the facility to access the funds to cover, essentially, room and board, or in other terms, the liability owed to us.</p> <p>In interview with the ED on 8-29-14 at 12:30 p.m., she indicated, "When I pulled [name of Resident #A's] admission paperwork, there was a note from the POA giving [name of the family member] permission to sign the admission paperwork. Anyway, he signed to not open a personal fund account. That was back in 2009." She indicated she could not locate any written authorization for the personal resident account for Resident #A.</p> <p>She indicated she had spoken with the front office staff person and this staff person indicated to her that she did not</p>			

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 08/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FLATROCK RIVER LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>know she needed to have a person sign to open an account. She indicated the front office staff person is the person who takes care of the personal fund accounts. She indicated the facility did not have a policy or procedure regarding personal fund accounts.</p> <p>In interview with the Front Office staff member on 8-29-14 at 1:35 p.m. , she indicated, "Part of my job is setting up the personal funds accounts when residents or families bring money in. I'm not privy to any of the resident's admission forms and paperwork. I just do what I am told by the administrator and the business office manager. I also take care of deposits for Medicare/Social Security checks. Like I said, I am not privy to any of the patient's paperwork."</p> <p>The ED provided a copy of the admission paperwork for Resident #A. The "Admission Agreement" had an undated note attached to multiple stapled pages that indicated the POA gave permission to a named family "to sign all paperwork" for Resident #A. Included in this packet of admission paperwork was a document entitled, "Trust Fund Authorization." This document indicated, "A Resident Trust Fund is an amount of money held by the Facility for Resident's personal use. (Examples of use: to allow for the</p>			

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 08/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FLATROCK RIVER LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>resident to pay for room and board, bedhold, beauty shop charges, cigarettes, postage stamps, or other similar expenses as desired by the Resident." This document was check-marked for the area which indicated, "No, at this time, I do not want a Trust Fund account held at the facility. I request all personal charges, such as trips, hair care, outings, and any other charges [be] put on my monthly bill." In review of this particular document, the resident's name and the authorized family member's signature and date were absent. This document had Resident #A's name handwritten on the lower portion of the document; handwritten after the document had been provided. This document was indicated to be "Page 27 of 31," in the Admission Agreement, indicated to have a development or revision date of January, 2004.</p> <p>1. b. Resident #A's clinical record was reviewed on 8-28-14 at 11:15 a.m. Her diagnoses included, but were not limited to, congestive heart failure, general weakness and neurotic depression. It indicated she was admitted to the facility 3-27-2009. In review of her most recent Minimum Data Set assessment, dated 8-11-14, it indicated resident #A was severely cognitively impaired.</p>			

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 08/29/2014	
NAME OF PROVIDER OR SUPPLIER FLATROCK RIVER LODGE				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
	<p>In interview with a family member on 8-28-14 at 11:50 a.m., she indicated there had been some confusion regarding Resident #A's finances and the family had met with persons from the facility twice in August, 2014. She indicated she still had many questions regarding Resident #A's personal funds account held at the facility.</p> <p>In interview with the facility's Executive Director (ED) on 8-28-14 at 2:15 p.m., she indicated Resident #A's POA (power of attorney) and another family member had met with her and other facility staff twice in August, 2014 to discuss the resident's financial situation and outstanding liability (bill) to the facility. She indicated there had been issues regarding inconsistent receipt of Resident #A's pension check from the POA, which was to have had 100% to go toward payment of the resident's liability (bill) to the facility.</p> <p>In interview with the ED on 8-29-14 at 10:30 a.m., she indicated, "I will admit, we have not been consistent in how we have deposited the pension check into her [Resident #A's] fund. Sometimes, it looks like, it was deposited into the resident's personal account and sometimes directly into the business account with acknowledgement as to</p>						

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 08/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FLATROCK RIVER LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>where it was from and for whom. My expectations are that the monies should be credited consistently. It makes things a little murky and hard to follow for someone trying to follow a paper trail. Another issue is we have tried to be very kind to the resident and family. They don't have a lot of money. So, there have been times when the POA might say she doesn't have enough money to pay for a beauty shop visit for the resident, so we made adjustments and left a certain amount of money in her personal account fund for her to be able to get her hair done."</p> <p>2. Resident #B's clinical record was reviewed on 8-29-14 at 10:05 a.m. Her diagnoses included, but were not limited to, chronic kidney disease and insomnia. It indicated she was admitted to the facility on 8-1-2012. In review of her most recent Minimum Data Set assessment, dated 7-22-14, it indicated she was moderately cognitively impaired.</p> <p>In interview with the Executive Director (ED) on 8-29-14 at 1:25 p.m., she indicated Resident #B's admission paperwork did not have a personal funds account authorization, but the facility had provided a personal funds account for the resident.</p>			

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 08/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FLATROCK RIVER LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>The ED indicated she had spoken with the front office staff person and this staff person indicated to her that she did not know she needed to have a person sign to open an account. She indicated the front office staff person is the person who takes care of the personal fund accounts. She indicated the facility did not have a policy or procedure regarding personal fund accounts.</p> <p>In interview with the Front Office staff member on 8-29-14 at 1:35 p.m. , she indicated, "Part of my job is setting up the personal funds accounts when residents or families bring money in. I'm not privy to any of the resident's admission forms and paperwork. I just do what I am told by the administrator and the business office manager. I also take care of deposits for Medicare/Social Security checks. Like I said, I am not privy to any of the patient's paperwork."</p> <p>The ED provided a copy of the admission paperwork for Resident #B. The "Admission Agreement" packet included a document entitled, "Trust Fund Authorization." This document indicated, "A Resident Trust Fund is an amount of money held by the Facility for Resident's personal use. (Examples of use: to allow for the resident to pay for room and board, bedhold, beauty shop</p>			

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 08/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FLATROCK RIVER LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	----------------------

	<p>charges, cigarettes, postage stamps, or other similar expenses as desired by the Resident." This document was check-marked for the area which indicated, "No, at this time, I do not want a Trust Fund account held at the facility. I request all personal charges, such as trips, hair care, outings, and any other charges [be] put on my monthly bill." In review of this particular document, the resident's name and the authorized family member's signature and date were absent. This document had Resident #B's name handwritten on the lower portion of the document; handwritten after the document had been provided. This document was indicated to be page "20" in the Admission Agreement and indicated to have a development or revision date of January, 2004.</p> <p>This Federal tag relates to Complaint IN00155213.</p> <p>3.1-6(b) 3.1-6(e)</p>			
--	---	--	--	--