

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 03/05/2014
--	---	--	---

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 IN00144156</p> <p>Complaint IN00144156 - Substantiated. Federal and State deficiencies related to the allegations are cited at F282, F323, F498 and F9999.</p> <p>Unrelated deficiency is cited.</p> <p>Survey dates: March 3, 4 and 5, 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: 5 NF: 38 Residential: 7 NCC: 8 Total: 58</p> <p>Census payor type: Medicare: 5 Medicaid: 38 Other: 15 Total: 58</p>	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 provisions 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 to render adequate care.	

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 03/05/2014
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	
F000282 SS=D	<p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March 12, 2014, by Janelyn Kulik, RN.</p> <p>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.</p> <p>Based on interview and record review, the facility failed to ensure the plans of care for 2 of 3 residents reviewed for falls in a sample of 3 were followed related to care plan interventions being in place prior to falls. (Resident #A, Resident #C, CNA #1 and CNA #4)</p> <p>Findings include:</p> <p>1. Resident #A's clinical record was reviewed on 3-3-14 at 2:00 p.m. Her diagnoses included, but were not limited to, skull fracture, rib fractures and multiple small hemorrhages to the right frontoparietal region of the brain, sustained 2-7-14, osteoarthritis, chronic joint pain,</p>	F000282	The facility does provide or arrange services in accordance with each resident's written plan of care. Staff identified as not following care plans were retrained or counseled if indicated. Nursing staff will be rein-serviced on the requirement to follow care plans (CNA assignment sheets) An audit will be completed for those identified at risk for falls. Care Plans and CNA assignment sheets will be checked for correctness. The DON or designee shall monitor for compliance of the Care Plan by conducting direct observation audits of the resident, using our safe Resident Handling observation tool. Audits on all shifts will be conducted 2 times/week for 2 months. Then 2 times/week for 4 months. Negative findings will	04/04/2014	

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 03/05/2014
--	---	--	---

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>osteoporosis, osteopenia, peptic ulcer disease, depression, anxiety, diabetes, asthma, high blood pressure, and dementia.</p> <p>In review of Resident #A's "Fall Assessments", dated 6-27-13, 7-5-13, 9-27-13, 12-18-13, 2-7-14 and 2-27-14, it indicated Resident #A was at risk for falls.</p> <p>In review of Resident #A's current care plan related to "Potential for Trauma-Falls," with an original date of 6-27-13 and revision date of 2-12-14, indicated to encourage resident to ask for assistance; instruct resident in use of adaptive equipment; observe for decline due to psychotropic (mediation) use; reassure resident staff will assist with activities of daily living; transfers to be conducted with 2 staff and mechanical lift; keep legs elevated in wheelchair with the use of the leg rests; use of tray to the right side of the wheelchair for her right arm; 2 staff to assist with toileting and with positioning in bed; keep the bed in low position and head of bed elevated when assisting the resident with eating in bed.</p> <p>On 3-5-14 at 9:15 a.m., the Director of Nursing (DON) provided a copy of</p>		<p>be reported to the Quality Assurance performance improvement (QAPI) Committee. Completion by: April 4th, 2014</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 03/05/2014
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 facility's "Incident Report Form," which was emailed to the Indiana State Department of Health (ISDH) on 2-10-14. The report indicated on 2-7-14 at 7:15 p.m., Resident #A was found in front of her wheelchair in the activity room. This report indicated the resident was assessed by the licensed nurse and sent immediately to the local emergency room with bruising and was diagnosed with a skull fracture. A handwritten note on the report identified this as the "1st report."</p> <p>In an interview with CNA #1 on 3-4-14 at 11:40 a.m., she indicated she was assigned to care for Resident #A on the evening shift of 2-7-14. She indicated after the resident had eaten supper, she took the resident down to her room to get her ready for bed as usual. She indicated she removed the resident's shoes and the foot pedals and footboard from the wheelchair. She indicated Resident #A told her she was not ready to go to bed yet and she returned her to the activity room. "I didn't get her shoes, foot pedals or footboard back on, just forgot." She indicated the resident was not toileted while she was in the resident's room, as she and the resident were in the room for</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 03/05/2014
--	---	--	---

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>approximately 2 minutes. She indicated she and CNA #3 had planned for her [CNA #1] to get the resident prepared for bed and for CNA #3 to meet her in Resident #A's room in order to transfer the resident from the wheelchair into the bed. She indicated, "It takes 2 people to transfer her." She indicated she and the resident met CNA #3 in the hallway as they returned to the activity room. She indicated she went to supper after assisting the resident into the activity room and had planned on assisting the resident with going to bed upon her return from her supper break.</p> <p>In an interview with CNA #1 on 3-4-14 at 11:40 a.m., she indicated she did have a CNA assignment sheet, "but did not look at it. I got written up for not following the assignment sheet."</p> <p>In review of Resident #A's "CNA Assignment Sheet", identified by the DON for 2-7-14, it indicated "Supportive Devices" to include, "Wheelchair with cushion, 1/2 tray on right side of W/C [wheelchair], foot board on wheelchair." It indicated she required 2 persons to assist with transfers.</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 03/05/2014
--	---	--	---

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 an interview with a family member of Resident #A on 3-4-14 at 9:20 a.m., she indicated Resident #A had the wheelchair safety/positioning devices of the 1/2 tray, foot pedals and footboard in place prior to her admission to the facility. She indicated the fall on 2-7-14 was Resident #A's first fall at the facility since her admission to the facility.</p> <p>2. Resident #C's clinical record was reviewed on 3-4-14 at 1:15 p.m. Her diagnoses included, but were not limited to, osteoarthritis, schizoaffective disorder, high blood pressure, congestive heart failure and diabetes.</p> <p>In an interview with Resident #C on 3-4-14 at 1:15 p.m., she indicated she also had been diagnosed with Parkinson's disease.</p> <p>In review of the nursing notes, incidents were documented on 12-23-13 at 8:20 a.m. and on 2-20-13 at 8:15 a.m. in which the resident was assisted with toileting by CNA staff while in the resident's bathroom.</p> <p>The "Incident Report," dated 12-23-14 at 8:20 a.m., indicated the resident had a witnessed fall in 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 03/05/2014
--	---	--	---

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>bathroom while toileting. It indicated the resident had no apparent injury. It indicated, "Resident assessed and assisted into her w/c [wheelchair] by staff x2 [2 staff persons]. CNA educated to always follow CNA assignment sheet. Resident was to have assist of 2 for transfers for toilet use. CNA did not follow assignment sheet and used 1 assist for resident."</p> <p>The "Incident Report," dated 2-20-14 at 8:15 a.m., indicated the resident was lowered to the floor with no apparent injury. It indicated the resident was being transferred from the toilet to the wheelchair. It indicated, "Resident is to have assist of 2 [persons] for transfers on and off the toilet and CNA transferred her with assist of one." It indicated, "CNA educated on following CNA assignment sheet." Review of faxes sent to Resident #C's attending physician on 12-23-13 at 9:30 a.m. and on 2-20-14 at 8:15 a.m., indicated the resident had been lowered to the floor and sustained no apparent injuries.</p> <p>Review of Resident #C's care plan related to potential for falls, dated 10-24-12 and updated on 9-4-13 and 12-30-13, indicated 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 03/05/2014	
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>required 1 assist for transfers and 2 assists for toileting.</p> <p>Review of the resident's "CNA Assignment Sheet" indicated she required 2 persons to assist her with toileting needs.</p> <p>In an interview with CNA #4 on 3-5-14 at 10:00 a.m., she indicated she had been providing care to Resident #C both times in which she had the assisted falls to the floor. She indicated both times she was toileting the resident by herself. She indicated the resident was not injured in either assisted fall. She indicated after the first assisted fall, the nurse spoke to her about making sure she had the aide assignment sheet with her and checking it to make sure she was doing what it said. CNA #4 indicated she received a written counseling after the second assisted fall. She indicated, "The aide assignment sheet both times said she should have 2 people assisting her with toileting."</p> <p>On 3-3-14 at 4:30 p.m., the DON provided a copy of a policy entitled, "Fall Assessment & Prevention Protocol." This policy indicated, "All staff members are regularly</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 03/05/2014
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>inservices on resident fall prevention and safety, including proper placement of safety devices, use of different kinds of available safety equipment and daily surveillance of possible hazards."</p> <p>On 3-5-14 at 9:15 a.m., the DON provided a copy of a policy entitled, "Assignments, CNA." This policy indicated, "The C.N.A. assignments are part of resident's plan of care and are prepared and reviewed by a licensed nurse and are issued on a daily basis...C.N.A.'s are expected to carry out their daily assignments in a professional manner and in accordance with established nursing procedures. Teaming with other C.N.A.'s for rounds and care giving is acceptable, however, the individual assigned holds the responsibility for all residents on his/her assignment..."</p> <p>This Federal tag relates to Complaint IN00144156.</p> <p>3.1-45(a)(2)</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 03/05/2014	
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			
F000323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure safety/positioning equipment of foot pedals and a footboard for one resident's wheelchair were in place while the resident was in the wheelchair, which contributed to the resident falling from the wheelchair and sustaining a skull fracture, rib fractures, with bruising to the right side of the body. (Resident #A) The facility also failed to ensure two staff members assisted with toileting needs, which resulted in a resident having two assisted falls to the floor with no injuries. (Resident #B)</p> <p>Findings include:</p> <p>1. Resident #A's clinical record was reviewed on 3-3-14 at 2:00 p.m. Her diagnoses included, but were not limited to, skull fracture, rib fractures and multiple small hemorrhages to the right frontoparietal region of the brain, sustained 2-7-14, osteoarthritis, chronic joint pain, osteoporosis, osteopenia, peptic</p>	F000323	The facility does ensure that the resident environment remains as free of accident hazards as is possible: and each resident does receive adequate supervision and assistance devices to prevent accidents. Staff identified as not follow care plans were retrained or counseled if indicated. Nursing staff will be rein-serviced on the requirement to follow care plans (CNA assignment sheets). An audit will be completed for those identified at risk for falls. Care Plans and CNA assignment sheets will be checked for correctness. The DON or designee shall monitor for compliance of the Care Plan by conducting direct observation audits of the resident using our Safe Resident Handling observation tool. Audits on all shifts will be conducted 3 times/week for 2 months. Then 2 times/week for 4 months. Negative findings will be reported to the Quality Assurance performance improvement (QAPI) Committee. Completion by: April 4th, 2014	04/04/2014			

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 03/05/2014
--	---	--	---

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>ulcer disease, depression, anxiety, diabetes, asthma, high blood pressure, and dementia. It indicated her date of admission was 6-27-13.</p> <p>In review of Resident #A's "Fall Assessments", dated 6-27-13, 7-5-13, 9-27-13, 12-18-13, 2-7-14 and 2-27-14, it indicated Resident #A was at risk for falls.</p> <p>In review of Resident #A;s current care plan related to "Potential for Trauma-Falls," with an original date of 6-27-13 and revision date of 2-12-14, it indicated to encourage resident to ask for assistance; instruct resident in use of adaptive equipment; observe for decline due to psychotropic (mediation) use; reassure resident staff will assist with activities of daily living; transfers to be conducted with 2 staff and mechanical lift; keep legs elevated in wheelchair with the use of the leg rests; use of tray to the right side of the wheelchair for her right arm; 2 staff to assist with toileting and with positioning in bed; keep the bed in low position and head of bed elevated when assisting the resident with eating in bed.</p> <p>A CT Scan of Resident's #A head, dated 2/7/14 at 7:19 p.m., indicated</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 03/05/2014
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 reason for the test was "fall with hematoma rt (right) forehead." The CT results indicated, "Multiple small hemorrhages (small bleeding areas) in the right frontoparietal region."</p> <p>A hospital "Discharge Summary," dated 2/12/14, indicated the resident had a discharge diagnosis of "Right frontoparietal contusion with a nondepressed underlying skull fracture from a fall out of a wheelchair" on 2/7/14. It indicated the resident was returning to the facility.</p> <p>On 3-5-14 at 9:15 a.m., the Director of Nursing (DON) provided a copy of the facility's "Incident Report Form," which was emailed to the Indiana State Department of Health (ISDH) on 2-10-14. The report indicated on 2-7-14 at 7:15 p.m., Resident #A was found in front of her wheelchair in the activity room. This report indicated the resident was assessed by the licensed nurse and sent immediately to the local emergency room with bruising and was diagnosed with a skull fracture. A handwritten note on the report identified this as the "1st report."</p> <p>On 3-4-14 at 10:30 a.m., the DON provided a copy of a follow up report</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 03/05/2014
--	---	--	---

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>of the "Incident Report Form" which was emailed to the ISDH on 2-12-14 at 8:30 p.m. The follow up report indicated the same information as the initial report and added the resident had been found lying on her right side with her right arm underneath her. It indicated a large hematoma was observed on the right side of her forehead. It indicated the CNA assigned to assist with Resident #A's care had taken her to her room to get her ready for bed at approximately 6:50 p.m. and had removed her shoes and the foot pedals and footboard from the wheelchair in preparation of going to bed. The resident had then indicated to the CNA that she was not ready to go to bed and wished to return to the activity room. The CNA then returned the resident to the activity room and informed the resident she would return later to get her ready for bed. It indicated at approximately 7:00 p.m., the charge nurse observed the resident in the activity room and the resident did not appear in any distress. It indicated at approximately 7:15 p.m., a visitor informed the nurse that a lady was lying on the floor of the activity room. It indicated, "The cause of the fall is undetermined. There were no witnesses...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 03/05/2014
--	---	--	---

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's care plan called for foot pedals and foot board which were not put back on when taken back to the activity room. This may or may not have been the cause of the accident." It indicated all nursing staff were educated on the "importance of following care plan [for each resident] and on CNA assignment sheets."</p> <p>In an interview with the DON on 3-3-14 at 4:30 p.m., she indicated on the evening in which Resident #A fell from her wheelchair, CNA #1 was working with the resident. She indicated CNA #1 had forgotten to replace the resident's foot pedals and footboard onto the wheelchair prior to returning the resident to the activity room.</p> <p>In an interview with CNA #1 on 3-4-14 at 11:40 a.m., she indicated she was assigned to care for Resident #A on the evening shift of 2-7-14. She indicated after the resident had eaten supper, she took her down to her room to get her ready for bed as usual. She indicated she removed the resident's shoes and the foot pedals and footboard of the wheelchair. She indicated Resident #A told her she was not ready to go to bed yet and</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 03/05/2014
--	---	--	---

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>she returned her to the activity room. "I didn't get her shoes, foot pedals or footboard back on, just forgot." She indicated the resident was not toileted while she was in the resident's room, as she and the resident were in the room for approximately 2 minutes. She indicated she and CNA #3 had planned for her [CNA #1] to get the resident prepared for bed and for CNA #3 to meet her in Resident #A's room in order to transfer the resident from the wheelchair to the bed. She indicated, "It takes 2 people to transfer her." She indicated she and the resident met CNA #3 in the hallway as they returned to the activity room. She indicated she went to supper after assisting the resident into the activity room and had planned on assisting the resident with going to bed upon her return from her supper break.</p> <p>In an interview with CNA #1 on 3-4-14 at 11:40 a.m., she indicated she did have a CNA assignment sheet, "but did not look at it. I got written up for not following the assignment sheet."</p> <p>In an interview with CNA #3 on 3-4-14 at 2:03 p.m., she indicated she was assigned to the same hall</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 03/05/2014
--	---	--	---

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>on which Resident #A resided on 2-7-14, but was not assigned to Resident #A. She indicated that evening, CNA #1 was going to get Resident #A ready for bed and that she [CNA #3] was to meet CNA #1 in Resident #A's room in order for them to transfer the resident from her wheelchair, then into bed. She indicated that getting Resident #A ready for bed included removing the wheelchair's foot pedals and footboard. She indicated as she was exiting another resident's room and planning on going to Resident #A's room, she met CNA #1 and Resident #A in the hall. She indicated CNA #1 told her that Resident #A was not ready to lie down yet. She indicated over the next several minutes [time unspecified], she did observe the resident sitting in her wheelchair in the activity room and appeared to be sitting up in a normal manner for the resident. She indicated she did see the resident's 1/2 tray in place, but did not notice if the foot pedals or footboard were in place. She indicated she was sitting at the care station (nurse's station) when a family member of another resident told her and LPN #2 that a lady was in the floor. She indicated she did not recall hearing an alarm sound</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 03/05/2014
--	---	--	---

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>and did not think Resident #A had alarms on her wheelchair at that time. She indicated during the process of assisting LPN #2 with caring for Resident #A, she did note the resident's wheelchair was in an upright position with no foot pedals in place. She indicated the resident did not indicate what had happened, but complained of pain to her forehead where she noted a hematoma. She indicated she did not observe any bleeding. She indicated LPN #2 called for the emergency services (EMT's), which arrived very quickly . She indicated this was the resident's first fall that she was aware of since her admission.</p> <p>In an interview with LPN #2 on 3-4-14 at 1:30 p.m., she indicated she was working the evening of Resident #A's fall on 2-7-14. She indicated CNA #1 had informed her Resident #A was not ready to go to bed, so she [CNA #1] had returned her in her wheelchair to the activity room. She indicated she was seated in the nurse's station, charting (documenting written information in residents's clinical records) which is located across the hall from the activity room. She indicated at one point, a male</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 03/05/2014
--	---	--	---

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 had yelled, "hello," at her from the activity room. She estimated this occurred at 7:15 p.m. She indicated at that point, she walked over to one of the windows to the activity room and observed Resident #A in the activity room, along with several other residents. She indicated she did not notice anything unusual about Resident #A at that time. She indicated she estimated approximately 10 minutes later, CNA #5 and a visitor in the facility said a lady was on the floor in the activity room. She indicated she did not hear any alarms, but did not think Resident #A was care planned for any alarms at that time as this was the first fall she could recall the resident having since she was admitted. LPN #2 indicated she and CNA #3 immediately responded to assist Resident #A. She indicated she assessed the resident immediately and noted a hematoma to the right side of her forehead and the resident was complaining of pain to the right hip, shoulder and elbow. She indicated the resident did not lose consciousness. She indicated the resident was on Coumadin(an anti-coagulant), but she did not observe any bleeding. She indicated the EMS arrived in less than 5 minutes after they were</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 03/05/2014
--	---	--	---

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>contacted. She indicated she observed the wheelchair with the 1/2 tray was in an upright position, but the foot pedals and footboard were not in place. She indicated CNA #1 had been at supper break during this time. She indicated when CNA #1 returned to the floor, she questioned CNA #1 about the foot pedals and footboard. She indicated CNA #1 "started crying, said she forgot; had gotten in a hurry. She acknowledged the foot pedals and footboard should have been in place."</p> <p>In review of Resident #A's "CNA Assignment Sheet", identified by the DON for 2-7-14, it indicated "Supportive Devices" to include, "Wheelchair with cushion, 1/2 tray on right side of W/C [wheelchair], foot board on wheelchair." It indicated she required 2 persons to assist with transfers.</p> <p>2. Resident #C's clinical record was reviewed on 3-4-14 at 1:15 p.m. Her diagnoses included, but were not limited to, osteoarthritis, schizoaffective disorder, high blood pressure, congestive heart failure and diabetes.</p> <p>In an interview with Resident #C on</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 03/05/2014	
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>3-4-14 at 1:15 p.m., she indicated she also had been diagnosed with Parkinson's disease.</p> <p>In review of Resident #C's care plan related to potential for falls, dated 10-24-12 and updated on 9-4-13 and 12-30-13, it indicated the resident required 1 assist for transfers and 2 assists for toileting.</p> <p>In review of the Resident #C's "CNA Assignment Sheet", it indicated she required 2 persons to assist her with toileting needs.</p> <p>In review of the nursing notes, incidents were documented on 12-23-13 at 8:20 a.m. and on 2-20-13 at 8:15 a.m. in which the resident was assisted with toileting by CNA staff while in the resident's bathroom.</p> <p>The "Incident Report," dated 12-23-14 at 8:20 a.m., indicated the resident had a witnessed fall in the bathroom while toileting. It indicated the resident had no apparent injury. It indicated, "Resident assessed and assisted into her w/c [wheelchair] by staff x2 [2 staff persons]. CNA educated to always follow CNA assignment sheet. Resident is to have assist of 2 for transfers for</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 03/05/2014
--	---	--	---

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>toilet use. CNA did not follow assignment sheet and used 1 assist for resident."</p> <p>The "Incident Report," dated 2-20-14 at 8:15 a.m., indicated the resident was lowered to the floor with no apparent injury. It indicated the resident was being transferred from the toilet to the wheelchair. It indicated, "Resident is to have assist of 2 [persons] for transfers on and off the toilet and CNA transferred her with assist of one." It indicated, "CNA educated on following CNA assignment sheet." Review of faxes sent to Resident #C's attending physician on 12-23-13 at 9:30 a.m. and on 2-20-14 at 8:15 a.m., indicated the resident had been lowered to the floor and sustained no apparent injuries.</p> <p>In an interview with CNA #4 on 3-5-14 at 10:00 a.m., she indicated she had been providing care to Resident #C both times in which she had the assisted falls to the floor. She indicated both times she was toileting the resident by herself. She indicated the resident was not injured in either assisted fall. She indicated after the first assisted fall, the nurse spoke to her about making sure she had the aide assignment</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 03/05/2014	
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>sheet with her and checking it to make sure she was doing what it said. CNA #4 indicated she received a written counseling after the second assisted fall. She indicated, "The aide assignment sheet both times said she should have 2 people assisting her with toileting."</p> <p>On 3-3-14 at 4:30 p.m., the DON provided a copy of a policy entitled, "Fall Assessment & Prevention Protocol." This policy indicated, "All staff members are regularly inservices on resident fall prevention and safety, including proper placement of safety devices, use of different kinds of available safety equipment and daily surveillance of possible hazards."</p> <p>On 3-5-14 at 9:15 a.m., the DON provided a copy of a policy entitled, "Assignments, CNA." This policy indicated, "The C.N.A. assignments are part of resident's plan of care and are prepared and reviewed by a licensed nurse and are issued on a daily basis...C.N.A.'s are expected to carry out their daily assignments in a professional manner and in accordance with established nursing procedures. Teaming with other C.N.A.'s for rounds and care giving</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 03/05/2014
--	---	--	---

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>is acceptable, however, the individual assigned holds the responsibility for all residents on his/her assignment..."</p> <p>The ISDH "Division of Long Term Care Nurse Aide Training Program," (July 1998) indicated, under "Topic 2: Role of the Nurse Aide" the following: "...The CNA must exhibit ethical behavior...Perform to the best of your ability...Carry out your supervisor's instructions..."</p> <p>This Federal tag relates to Complaint IN00144156.</p> <p>3.1-45(a)(2)</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 03/05/2014	
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			
F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to</p>	F000441	The facility does provide a safe sanitary and comfortable	04/04/2014			

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 03/05/2014	
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>ensure staff utilize appropriate infection control methods, including not placing items soiled with feces on the bedside table for 1 of 3 residents reviewed for infection control in a sample of 3. (Resident #A and CNA #4)</p> <p>Findings include:</p> <p>During a care observation with Resident #A on 3-4-14 at 9:15 a.m., CNA #4 was observed to cleanse the resident's rectal area, which had been soiled with feces, with a moistened washcloth, then place the used washcloth onto the resident's bedside table. CNA #4 then was observed to dry the resident's rectal area with a towel and then place the used towel on the bedside table. Upon completion of care, CNA #4 placed the used linens in a plastic bag and the plastic bag was removed from the resident's room.</p> <p>In an interview with CNA #4 and the Director of Nursing (DON) on 3-4-14 at 9:35 a.m., CNA #4 indicated, "Normally, I would put the used things [linens] on the floor or into a [plastic] bag. I just didn't do it this morning." The DON indicated she would ensure Resident #A's bedside table was sanitized.</p>		<p>environment to help prevent the development and transmission of disease and infection. Staff observed not following facility infection policies have been counseled. All nursing staff were rein-serviced on the facility infection control policies including placement of soiled incontinent products, clothing and linens. The DON or designee shall monitor for compliance by conducting random time and day care round audits 2 times/week for 2 months then weekly for 4 months. Any negative findings will be brought to Quality Assurance performance improvement (QAPI) Committee. Completion by: April 4th, 2014</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 03/05/2014
--	---	--	---

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
F000498 SS=G	<p>In an interview with the DON on 3-5-14 at 1:40 p.m., she indicated the facility utilizes the ISDH (Indiana State Department of Health) CNA Training Manual in regards to infection control and resident care.</p> <p>The ISDH "Division of Long Term Care Nurse Aide Training Program," (July 1998) indicated, under "Topic 5: Infection Control," to use Standard Precautions. "Standard Precautions are guidelines developed by the Center of Disease Control (CDC) to reduce the risk of transmission of pathogens from both known and unknown pathogens."</p> <p>3.1-18(a)</p> <p>483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.</p> <p>Based on interview and record review, the facility failed to ensure CNA's followed care guidelines. This deficient practice resulted in 2 of 3 residents reviewed for falls, in a sample of 3, having falls in which</p>	F000498	The facility does ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for resident's needs as identified through resident assessments and described in the plan of care. Staff identified as not following	04/04/2014

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 03/05/2014
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>one resident fell from a wheelchair and a second resident had 2 assisted falls to the floor. (Resident #A, Resident #C, CNA #1 and CNA #4)</p> <p>Findings include:</p> <p>1. Resident #A's clinical record was reviewed on 3-3-14 at 2:00 p.m. Her diagnoses included, but were not limited to, skull fracture, rib fractures and multiple small hemorrhages to the right frontoparietal region of the brain, sustained 2-7-14, osteoarthritis, chronic joint pain, osteoporosis, osteopenia, peptic ulcer disease, depression, anxiety, diabetes, asthma, high blood pressure, and dementia. It indicated her date of admission was 6-27-13.</p> <p>In review of Resident #A's "CNA Assignment Sheet", identified by the DON for 2-7-14, it indicated "Supportive Devices" to include, "Wheelchair with cushion, 1/2 tray on right side of W/C [wheelchair], foot board on wheelchair." It indicated she required 2 persons to assist with transfers.</p> <p>In review of Resident #A's current care plan related to "Potential for Trauma-Falls," with an original date</p>		<p>care plans were retrained or counseled if indicated. Nursing staff will be rein-serviced on the requirement to follow care plans (CNA assignment sheets). All CNA assignment sheets were audited to ensure completeness related to fall interventions and transfer needs. All CNA's completed return demonstration of knowledge of care plan content after training. The DON or designee shall monitor for compliance on all shifts by conducting direct observation audits using our Safe Resident Handling observation tool. Audits will be conducted 3 times/week for 2 months then 2 times/week for 4 months. Negative findings will be reported to the Quality Assurance performance improvement (QAPI) Committee. Completion by: April 4th, 2014</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 03/05/2014
--	---	--	---

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>of 6-27-13 and revision date of 2-12-14, it indicated to encourage resident to ask for assistance; instruct resident in use of adaptive equipment; observe for decline due to psychotropic (mediation) use; reassure resident staff will assist with activities of daily living; transfers to, be conducted with 2 staff and mechanical lift; keep legs elevated in wheelchair with the use of the leg rests; use of tray to the right side of the wheelchair for her right arm; 2 staff to assist with toileting and with positioning in bed; keep the bed in low position and head of bed elevated when assisting the resident with eating in bed.</p> <p>A CT Scan of Resident's #A head, dated 2/7/14 at 7:19 p.m., indicated the reason for the test was "fall with hematoma rt (right) forehead." The CT results indicated, "Multiple small hemorrhages (small bleeding areas) in the right frontoparietal region."</p> <p>A hospital "Discharge Summary," dated 2/12/14, indicated the resident had a discharge diagnosis of "Right frontoparietal contusion with a nondepressed underlying skull fracture from a fall out of a wheelchair" on 2/7/14. It indicated the resident was returning to 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 03/05/2014
--	---	--	---

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>facility.</p> <p>On 3-5-14 at 9:15 a.m., the Director of Nursing (DON) provided a copy of the facility's "Incident Report Form," which was emailed to the Indiana State Department of Health (ISDH) on 2-10-14. The report indicated on 2-7-14 at 7:15 p.m., Resident #A was found in front of her wheelchair in the activity room. This report indicated the resident was assessed by the licensed nurse and sent immediately to the local emergency room with bruising and was diagnosed with a skull fracture. A handwritten note on the report identified this as the "1st report."</p> <p>On 3-5-14 at 9:15 a.m., the Director of Nursing (DON) provided a copy of the facility's "Incident Report Form," which was emailed to the Indiana State Department of Health (ISDH) on 2-10-14. The report indicated on 2-7-14 at 7:15 p.m., Resident #A was found in front of her wheelchair in the activities room. This report indicated the resident was assessed by the licensed nurse and sent immediately to the local emergency room with bruising and was diagnosed with a skull fracture. A handwritten note on the report identified this as the "1st report."</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 03/05/2014
--	---	--	---

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 an interview with the DON on 3-3-14 at 4:30 p.m., she indicated on the evening in which Resident #A fell from her wheelchair, CNA #1 was working with the resident. She indicated CNA #1 had forgotten to replace the resident's foot pedals and footboard onto the wheelchair prior to returning the resident to the activity room.</p> <p>In an interview with CNA #1 on 3-4-14 at 11:40 a.m., she indicated she was assigned to care for Resident #A on the evening shift of 2-7-14. She indicated after the resident had eaten supper, she took her down to her room to get her ready for bed as usual. She indicated she removed the resident's shoes and the foot pedals and footboard of the wheelchair. She indicated Resident #A told her she was not ready to go to bed yet and she returned her to the activity room. "I didn't get her shoes, foot pedals or footboard back on, just forgot." She indicated the resident was not toileted while she was in the resident's room, as she and the resident were in the room for approximately 2 minutes. She indicated she and CNA #3 had planned for her [CNA #1] to get 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 03/05/2014
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 prepared for bed and for CNA #3 to meet her Resident #A's room in order to transfer the resident from the wheelchair to the bed. She indicated, "It takes 2 people to transfer her." She indicated she and the resident met CNA #3 in the hallway as they returned to the activity room. She indicated she went to supper after assisting the resident into the activity room and had planned on assisting the resident with going to bed upon her return from her supper break.</p> <p>In an interview with CNA #1 on 3-4-14 at 11:40 a.m., she indicated she did have a CNA assignment sheet, "but did not look at it. I got written up for not following the assignment sheet."</p> <p>2. Resident #C's clinical record was reviewed on 3-4-14 at 1:15 p.m. Her diagnoses included, but were not limited to, osteoarthritis, schizoaffective disorder, high blood pressure, congestive heart failure and diabetes.</p> <p>In an interview with Resident #C on 3-4-14 at 1:15 p.m., she indicated she also had been diagnosed with Parkinson's disease.</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 03/05/2014
--	---	--	---

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 review of the nursing notes, incidents were documented on 12-23-13 at 8:20 a.m. and on 2-20-13 at 8:15 a.m. in which the resident was assisted with toileting by CNA staff while in the resident's bathroom.</p> <p>The "Incident Report," dated 12-23-14 at 8:20 a.m., indicated the resident had a witnessed fall in the bathroom while toileting. It indicated the resident had no apparent injury. It indicated, "Resident assessed and assisted into her w/c [wheelchair] by staff x2 [2 staff persons]. CNA educated to always follow CNA assignment sheet. Resident is to have assist of 2 for transfers for toilet use. CNA did not follow assignment sheet and used 1 assist for resident."</p> <p>The "Incident Report," dated 2-20-14 at 8:15 a.m., indicated the resident was lowered to the floor with no apparent injury. It indicated the resident was being transferred from the toilet to the wheelchair. It indicated, "Resident is to have assist of 2 [persons] for transfers on and off the toilet and CNA transferred her with assist of one." It indicated, "CNA educated on following CNA assignment sheet." Review of faxes</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 03/05/2014
--	---	--	---

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>sent to Resident #C's attending physician on 12-23-13 at 9:30 a.m. and on 2-20-14 at 8:15 a.m., indicated the resident had been lowered to the floor and sustained no apparent injuries.</p> <p>Review of Resident #C's care plan related to potential for falls, dated 10-24-12 and updated on 9-4-13 and 12-30-13, it indicated the resident required 1 assist for transfers and 2 assists for toileting. Review of the resident's "CNA Assignment Sheet" indicated she required 2 persons to assist her with toileting needs.</p> <p>In interview with CNA #4 on 3-5-14 at 10:00 a.m., she indicated she had been providing care to Resident #C both times in which she had the assisted falls to the floor. She indicated both times she was toileting the resident by herself. She indicated the resident was not injured in either assisted fall. She indicated after the first assisted fall, the nurse spoke to her about making sure she had the aide assignment sheet with her and checking it to make sure she was doing what it said. CNA #4 indicated she received a written write up after the second assisted fall. She indicated,</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 03/05/2014
--	---	--	---

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 aide assignment sheet both times said she should have 2 people assisting her with toileting."</p> <p>On 3-3-14 at 4:30 p.m., the DON provided a copy of a policy entitled, "Fall Assessment & Prevention Protocol." This policy indicated, "All staff members are regularly inservices on resident fall prevention and safety, including proper placement of safety devices, use of different kinds of available safety equipment and daily surveillance of possible hazards."</p> <p>On 3-5-14 at 9:15 a.m., the DON provided a copy of a policy entitled, "Assignments, CNA." This policy indicated, "The C.N.A. assignments are part of resident's plan of care and are prepared and reviewed by a licensed nurse and are issued on a daily basis...C.N.A.'s are expected to carry out their daily assignments in a professional manner and in accordance with established nursing procedures. Teaming with other C.N.A.'s for rounds and care giving is acceptable, however, the individual assigned holds the responsibility for all residents on his/her assignment..."</p> <p>The ISDH "Division of Long Term</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 03/05/2014
--	---	--	---

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
F009999	<p>Care Nurse Aide Training Program," (July 1998) indicated, under "Topic 2: Role of the Nurse Aide" the following: "...The CNA must exhibit ethical behavior...Perform to the best of your ability...Carry out your supervisor's instructions..."</p> <p>This Federal tag relates to Complaint IN00144156.</p> <p>3.1-14(i)</p>			
	<p>3.1-28 STAFF TREATMENT OF RESIDENTS</p> <p>(c) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property, are reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures, including the state survey and certification agency.</p> <p>This state rule was not met as evidenced by:</p>	F009999	<p>The facility does ensure that all alleged violations involving mistreatment, neglect, or abuse including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures, including the state survey and certification agency. The NHA and DON reviewed the Indiana State Department of Health Division of Long Term Care Reportable incidents policy. All reportable incidents will be audited for timeliness and brought to our monthly Quality Assurance performance improvement</p>	04/04/2014

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 03/05/2014
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>Based on interview and record review, the facility failed to ensure a resident's fall in which she sustained a skull fracture, rib fractures, with bruising to the right side of the body was reported within 24 hours to the Indiana State Department of Health after becoming aware of the fall with significant injury. This deficient practice affected 1 of 3 residents reviewed for falls in a sample of 3. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 3-3-14 at 2:00 p.m. Her diagnoses included, but were not limited to, skull fracture, rib fractures and multiple small hemorrhages to the right frontoparietal region of the brain, sustained 2-7-14, osteoarthritis, chronic joint pain, osteoporosis, osteopenia, peptic ulcer disease, depression, anxiety, diabetes, asthma, high blood pressure, and dementia.</p> <p>Review of Resident #A's admission Minimum Data Set assessment, dated 7-5-13, indicated she was severely cognitively impaired. It indicated she was dependent for bed mobility and indicated she</p>		(QAPI) Committee. The administrator or designee shall monitor for compliance monthly for 6 months. Completion by: April 4th, 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 03/05/2014	
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>required extensive assistance of 2 or more persons with transfers from one surface to another. It indicated she was not steady unless assisted to stabilize with other human assistance for moving from seated to standing position, for walking with assistive devices, for moving on and off the toilet or for moving from surface to surface. It indicated she did not turn around and face the opposite direction while walking. It indicated she did not ambulate and used a wheelchair for mobility about the facility.</p> <p>On 3-5-14 at 9:15 a.m., the Director of Nursing (DON) provided a copy of the facility's "Incident Report Form," which was emailed to the Indiana State Department of Health (ISDH) on 2-10-14, time not indicated. The report indicated on 2-7-14 at 7:15 p.m., Resident #A was found in front of her wheelchair in the activities room. This report indicated the resident was assessed by the licensed nurse and sent immediately to the local emergency room with bruising and was diagnosed with a skull fracture. A handwritten note on the report identified this as the "1st report."</p> <p>In an interview with LPN #2 on</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 03/05/2014	
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>3-4-14 at 1:20 p.m., she indicated she was made aware of the resident's injuries of "probable minor brain bleed" by the local emergency room and planned transport to a larger hospital within an hour or so of the resident being transported to the hospital from the facility on 2-7-14 at approximately 7:30 p.m.</p> <p>On 3-5-14 at 9:15 a.m., the DON provided a copy of a policy entitled, "Reportable Incident Policy." This policy indicated, "Facilities are required by law to report incidents within 24 hours of occurrence to [ISDH] Long Term Care Division...Significant Injuries: Examples, but not inclusive of all...serious unusual and/or life threatening injury..."</p> <p>In an interview with the DON on 3-5-14 at 11:45 a.m., she indicated the reason for the late reporting was the facility was "still in the process of gathering information and conducting the investigation and putting all the pieces of the puzzle together."</p> <p>This State tag relates to Complaint IN00144156.</p> <p>3.1-28(a)(1)(c)</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 03/05/2014
--	---	--	---

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