STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155630	A. BUILDING -- B. WING	04/28/2025

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/28/25 Facility Number: 001126 Provider Number: 155630 AIM Number: 20011300 At this Emergency Preparedness survey, Flatrock River Lodge was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 63 certified beds. At the time of the survey, the census was 28. Quality Review completed on 05/05/25	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/28/25 Facility Number: 001126 Provider Number: 155630 AIM Number: 200011300 At this Life Safety Code survey, Flatrock River Lodge was found not in compliance with	K 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 solely because the provisions of law require it. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Leah Staley Hillenburg	Clinical and Quality Consultant	05/18/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard-wired smoke detectors in all resident sleeping rooms. The facility has Assisted Living rooms on the 400 Hall which are not separated by latching fire doors and some Assisted living rooms on the same corridor with Skilled Nursing rooms. The facility has a capacity of 63 and had a census of 28 at the time of this survey. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility had a detached garage used for storage which was not sprinkled. Quality Review completed on 05/05/25		residents nor are they of such character as to limit the facility's capacity to render adequate care. The statement of decencies has been taken to the facilities Quality Assurance/Assessment Committee. Substantial Compliance date: 5-25-25 The facility respectfully requests paper compliance.	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Based on record review, observation and interview; the facility failed to document monthly and annual testing for all battery backup lights in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30	K 0291	Facility does perform regular testing of the battery backup light to ensure function with monthly generator load test. No residents were affected related to this alleged deficient practice. Maintenance Director has been reeducated on documentation utilizing current forms that identify	05/01/2025

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	seconds, except as otherwise permitted by 7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generator Battery Powered Light" testing documentation for the most recent twelve month period with the Maintenance Supervisor at 10:33 a.m. on 04/28/25, an itemized list by light location for monthly and annual 90-minute battery operated light testing documentation for the most recent twelve month period was not available for review. The aforementioned light testing documentation was left blank. Review of the "Battery Loaded Emergency Lighting Test" section of "Thirty Day Maintenance Summary" documentation for the most recent twelve month period was also left blank. Review of "Generator Load Testing Form-Annual" testing documentation indicated "Yes Comes On" in response to item "16. Emergency Lighting" for monthly load testing for the most recent twelve month period but it did not indicate the duration of the test. Based on interview at 10:33 a.m. on 04/28/25, the Maintenance Supervisor stated the facility has		test duration of light for minimum of 30seconds monthly and 1 ½ hour consecutive annually. Administrator will verify documentation of emergency lighting monthly for 3 months. Any adverse findings will be reported to facility QAPI.	

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	one battery operated light located at the emergency generator location, he tests the light every time he looks at the generator but agreed the aforementioned documentation did not document monthly 30-second functional testing and annual 90-minute testing for the battery backup light. Based on observations with the Maintenance Supervisor at 12:15 p.m. on 04/28/25, one battery operated emergency light was located at the emergency generator location outside the building on the southeast side of the facility which illuminated when its respective test button was pushed. These findings were reviewed with the Clinical & Quality Consultant and the Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0351 SS=D Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to maintain the ceiling construction outside of 1 of 1 kitchens in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect over 2 kitchen staff. Findings include: Based on observations with the Maintenance Supervisor at 12:26 p.m. on 04/28/25, one of two ceiling mounted sprinkler locations in the hall outside the main Electrical Room near the kitchen	K 0351	Facility does maintain sprinkler system. Identified ceiling mounted sprinkler outside Electrical Room near kitchen had been identified by facility and vendor scheduled to replace escutcheon. No residents were affected related to this alleged deficient practice. Vendor to replace escutcheon identified in 2567 as well as 2 others 5-22-25 as scheduled. Audit of other ceiling mounted sprinkler locations conducted with no other findings. Maintenance Director has been educated on ensuring the escutcheons are in place post	05/25/2025

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	had a missing escutcheon which exposed the interstitial space above. Based on interview at 12:26 p.m. on 04/28/25, the Maintenance Supervisor agreed the aforementioned sprinkler location was missing its escutcheon. These findings were reviewed with the Clinical & Quality Consultant and the Maintenance Supervisor during the exit conference. 3.1-19(b)		vendor visit and when repairs to regions around the ceiling mounted sprinklers occurs. Maintenance Director or designee will audit sprinkler escutcheons after each vendor visit or if repairs occur to occur to area around ceiling mounted sprinkler system for 3 months. Any adverse findings will be reported to facility QAPI.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review, observation and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.3.2.1 states that all valves shall be inspected weekly. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on record review with the Maintenance Supervisor at 11:25 a.m. on 04/28/25, monthly	K 0353	Facility does maintain sprinkler system. Maintenance Director makes daily rounds to identify potential condition changes to wet sprinkler system. No residents were affected related to this alleged deficient practice. Vendor does inspect with documentation on routine basis. Maintenance Director has been provided education on required documentation including recording his valve and gauge inspections of wet sprinkler system. Administrator or designee will review Maintenance Directors documentation monthly to ensure complete for 3 months. Any adverse findings will be reported to facility QAPI.	05/01/2025

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	sprinkler system gauge and valve inspection documentation for the most recent twelve month period was not available for review. Based on interview at 11:25 a.m. on 04/28/25, the Maintenance Supervisor stated he does a daily walk through of the facility which includes the sprinkler system, but he doesn't record sprinkler system gauge and valve checks. Review of the sprinkler contractor's "Sprinkler System Inspection Form" documentation indicated sprinkler system gauge and valve checks were recorded by the contractor on 03/22/24, 07/25/24, 10/11/14 and on 01/09/25. Based on observations with the Maintenance Supervisor at 12:45 p.m. on 04/28/25, the facility has a supervised wet sprinkler system and had one sprinkler system water pressure gauge. These findings were reviewed with the Clinical & Quality Consultant and the Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Based on record observation and interview, the facility failed to ensure 1 of 20 portable fire extinguishers were inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a	K 0355	Portable fire extinguishers are inspected routinely with regular maintenance by Vendor. Identified extinguisher in beauty shop inspected with documentation recorded. All other extinguishers had documentation recorded. Maintenance Director counseled and reeducated on documentation requirement related to monthly inspection of fire extinguishers with review of all locations placed	05/01/2025

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	minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Beauty Shop. Findings include: Based on observations with the Maintenance Supervisor at 12:50 p.m. on 04/28/25, the wall mounted ABC type portable fire extinguisher installed in the Beauty Shop had missing monthly inspection documentation on the contractor affixed maintenance tag for the two month period of February 2025 and March 2025. The portable fire extinguisher inspection contractor had affixed a hanging tag to the fire extinguisher stating the most recent annual maintenance was performed in January 2025. Based on interview at 12:50 p.m. on 04/28/25, the Maintenance Supervisor stated additional monthly fire extinguisher inspection documentation was not available for review and agreed the aforementioned portable fire extinguisher location had missing monthly inspection documentation for February and March 2025. These findings were reviewed with the Clinical & Quality Consultant and the Maintenance Supervisor during the exit conference.		in facility. Administrator or designee will verify monthly inspection with documentation of all extinguishers to ensure complete for 3 months. Any adverse findings will be reported to facility QAPI.	

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K 0521 SS=F Bldg. 01	3.1-19(b) NFPA 101 HVAC Based on record review, observation and interview, the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance within the most recent four year period in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states that each damper shall be tested and inspected 1 year after installation. The test and inspection frequency shall be every 4 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. Section 19.4.3 states that full unobstructed access to the fire damper shall be verified and corrected as required. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the fire damper inspection	K 0521	Facility does ensure fire damper inspection is completed. Vendor did inspect with repairs documented on 10/11/21. This document has been reviewed in prior years with no findings or concerns shared with facility. No residents were affected related to this alleged deficient practice. Vendor scheduled to complete facility Damper inspections, testing and provide detailed list of each location with any repairs on 5-22-25. Maintenance Director or designee will ensure vendor provides 4-year inspection after visit 5/22/25 that includes testing/inspection and location of each damper with any repairs completed. Any adverse findings will be reported to Facility QAPI.	05/25/2025

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	contractor's letter dated 10/11/21 with the Maintenance Supervisor at 10:30 a.m. on 04/28/25, fire damper inspection and maintenance documentation within the most recent four year period was not itemized by fire damper location. In addition, the 10/11/21 documentation stated, "a visual inspection was performed on 30 fire dampers" at the facility but did not state the fire dampers were tested and also stated "fusible links were broken on two of the fire dampers". Based on interview at 10:30 a.m. on 04/28/25, the Maintenance Supervisor stated additional fire damper inspection documentation within the most recent four year period was not available for review and agreed the 10/11/21 fire damper inspection documentation was not itemized by damper location and did not indicate the dampers were tested for closure or repaired if needing repair. Based on observations with the Maintenance Supervisor at 1:01 p.m. on 04/28/25, a fire damper was installed in HVAC ductwork above a ceiling access panel in the bathroom for resident sleeping Room 307. No inspection and testing documentation was affixed to this damper location. Based on interview at 1:01 p.m. on 04/28/25, the Maintenance Supervisor stated additional fire dampers were located throughout the facility and agreed it could not be ensured fire dampers in the facility were tested for closure within the most recent four year period. These findings were reviewed with the Clinical & Quality Consultant and the Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills			

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	Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the first shift for three of four calendar quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Fire Drill Report" documentation with the Maintenance Supervisor at 11:20 a.m. on 04/28/25, three of four first shift fire drills conducted within the most recent twelve month period on 09/27/24, 12/16/24 and on 01/07/25 were conducted at, respectively, 9:50 a.m., 10:30 a.m. and 10:30 a.m. Based on interview at 11:20 a.m. on 04/28/25, the Maintenance Supervisor stated the facility operates three shifts per day, additional first shift fire drill documentation within the most recent twelve month period was not available for review and agreed the aforementioned first shift fire drills were not conducted at unexpected times under varying conditions. These findings were reviewed with the Clinical & Quality Consultant and the Maintenance Supervisor during the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	Facility does conduct fire drills to ensure staff are familiar with procedures as component of Emergency Preparedness. No residents were affected related to this alleged deficient practice. Maintenance Director counseled and reeducated on performing fire drills at unexpected times under varying conditions. Directed times as well as condition for each fire drill will be in collaboration with facility Administrator. Administrator or designee will verify documentation of fire drills to ensure they are held at the directed times monthly for 6 months. Any adverse findings will be reported to Facility QAPI.	05/14/2025
K 0914 SS=D Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Based on record review, observation and interview; the facility failed to ensure nonhospital-grade electrical receptacles that failed annual testing in 2 of over 50 resident rooms were replaced with hospital-grade receptacles. NFPA	K 0914	Facility direction has been to replace non hospital grade receptacles with hospital grade ones when receptacles fail annual testing, need replaced, upon	05/01/2025

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	70, The National Electrical Code, 2011 Edition, at Article 517.18(B) states each patient bed location shall be provided with a minimum of four receptacles. They shall be permitted to be of the single, duplex, or quadruplex type, or any combination of the three. All receptacles, whether four or more, shall be listed "hospital grade" and so identified. It is not intended that there be a total, immediate replacement of existing non-hospital grade receptacles. It is intended, however, that non-hospital grade receptacles be replaced with hospital grade receptacles upon modification of use, renovation, or as existing receptacles need replacement. This deficient practice could affect over 2 residents. Findings include: Based on review of "Maintenance-Receptacle Testing" documentation dated 2024 with the Maintenance Supervisor at 11:20 a.m. on 04/28/25, select electrical receptacles in outlet boxes in resident sleeping Room 203 and Room 209 failed annual inspection and testing. Receptacle locations identified as "1 and 2" in resident Room 203 stated they "need replaced" due to failing a polarity check and retention force testing. The receptacle location identified as "#1 duplex" in Room 209 stated they need replaced because "tension fail ground". Based on interview at 11:20 a.m. on 04/28/25, the Maintenance Supervisor stated the receptacles which failed testing and needed replacement may not have been replaced with hospital-grade receptacles. Based on observations with the Maintenance Supervisor at 12:44 p.m. on 04/28/25, receptacle locations #1 and #2 in resident sleeping Room 203 were not hospital-grade. Based on observations with the Maintenance Supervisor at 12:48 p.m. on 04/28/25, receptacle location #1 in resident sleeping Room		modification of need or with renovations. No residents were affected related alleged deficient practice. Maintenance Director provided reeducation on receptacle testing , documentation and expectation to change to hospital grade receptacles as indicated need. Administrator will review receptacle testing logs monthly with Maintenance Director to ensure hospital grade receptacles have been used to replace non hospital grade if identified need. Any adverse findings will be reported to facility QAPI.	

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	209 was not hospital-grade. These findings were reviewed with the Clinical & Quality Consultant and the Maintenance Supervisor during the exit conference. 3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review, observation and interview; the facility failed to document a complete written record of monthly generator load testing for 5 months of the most recent 12 month period in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 2010 Edition, Section 8.4.1 states Emergency Power Supply Systems (EPSS), including all appurtenant components shall be inspected weekly and exercised under load at least monthly. Section 8.4.2.4 states spark-ignited generator sets shall be exercised at least once a month with the available EPSS load for 30 minutes or until the water temperature and the oil pressure have stabilized. NFPA 99, 2012 Edition, Section 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Generator Log" testing documentation for the most recent twelve month period with the Maintenance Supervisor at 10:30 a.m. on 04/28/25, monthly testing documentation for the five month period of April 2024 through	K 0918	Facility does routine testing of the generator and transfer switches to ensure capable of supplying service. No residents were affected related to alleged deficient practice. Maintenance Director was counseled and reeducated on complete documentation on approved form for all inspection, maintenance and exercises/testing of generator. Administrator or designee will verify documentation related to weekly, monthly and annual exercise/inspection and maintenance of generator is complete for 6 months. Any adverse findings will be reported to facility QAPI.	05/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155630	A. BUILDING 01 B. WING	04/28/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	August 2024 was incomplete as it was only listed as "weekly test" or "4 hour load test" for that five month period. Review of the "Generator Monthly Load Test" section of "Thirty Day Maintenance Summary" documentation for April 2024 through August 2024 was left blank. Based on interview at 10:30 a.m. on 04/28/25, the Maintenance Supervisor stated he wanted to go to a more detailed load testing form, but they hadn't done that yet and agreed monthly testing documentation for the five month period of April 2024 through August 2024 was not available for review. Based on observations with the Maintenance Supervisor at 12:15 p.m. on 04/28/25, the facility has one natural-gas fired emergency generator located outside the building on the southeast side of the property. Manufacturer's nameplate documentation affixed to the generator indicated it was rated at 20 kW. These findings were reviewed with the Clinical & Quality Consultant and the Maintenance Supervisor during the exit conference. 3.1-19(b)			