STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155630	A. BUILDING 00 B. WING	03/08/2024

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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: March 4, 5, 6, 7, and 8, 2024 Facility number: 001126 Provider number: 155630 AIM number: 20001130 Census Bed Type: SNF/NF: 34 Total: 34 Census Payor Type: Medicare: 2 Medicaid: 25 Other: 7 Total: 34 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 14, 2024	F 0000	Preparation and execution of this plan of correction does not constitute admission or agreement by this facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because the 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 or render adequate care.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chad Smyth	RDO	04/10/2024

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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	Based on observation, interview and record review the facility failed to complete an accurate skin assessment and provide treatment for a resident experiencing bilateral foot and ankle swelling for 1 of 1 resident reviewed for edema (Resident 30). Finding include: During an observation and interview with Resident 30 on 3/05/24 at 11:39 a.m., the resident had bilateral feet and ankle swelling. The resident indicated they had been swollen for a week and she needed a "water pill". The resident was unable to tie her tennis shoes all the way due to the swelling. The resident indicated her feet and ankles felt tight but she was not experiencing pain. During an observation and interview with Resident 30 on 3/06/24 at 11:11 a.m., the resident was observed to have bilateral swelling of her feet and ankles and was not able to tie her shoes due to the swelling. The resident indicated the facility had not provided treatment for the swelling. The resident indicated she had reported the swelling to all the staff. During an observation on 3/07/24 at 1:53 p.m., Resident 30 was observed to have bilateral swelling of her feet and ankles and was unable to tie her shoes due to the swelling. Review of the record of Resident 30 on 3/6/24 at 11:50 a.m., indicated the diagnoses included, but were not limited to, hypertension, arthritis, L arm post polio contractures and peripheral edema. The skin and body assessment for Resident 30, dated 3/6/24, indicated the resident had no skin	F 0684	=”” b=””> **F684 Based on the comprehensive assessment of a resident, this facility does ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents’ choices.** **Resident 30 was reassessed and provider notified of results. New orders were obtained and careplan was updated.** **Skin assessments were completed on other residents with no missed findings.** **All licensed staff were re-educated on the facility Skin Care Management policy on 03/27/2024.** **DON or designee will verify accuracy of weekly skin assessments for 5 residents weekly for 4 weeks and then monthly for an additional 2 months to ensure continued compliance.** **Any negative finding will be brought to the facility Quality Assurance Performance Improvement (QAPI) Committee.** **=”” b=””>** **=”” b=””>**	03/27/2024

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	issues and no edema. The Admission Minimum Data (MDS) assessment for Resident 30, dated 1/26/24, indicated the resident was cognitively intact, decisions consistent and reasonable. During an interview with the Administrator in Training on 3/07/24 at 1:58 p.m., indicated the nurses were responsible to complete a weekly skin assessment for Resident 30. The resident's bilateral feet and ankle swelling was reported at this time. The physician order for Resident 30, dated 3/7/24 at 3:38 p.m., indicated the resident was ordered Ted hose in the morning and off at night. The skin management policy provided by the Regional Clinical Liaison on 3/8/24 at 9:30 a.m., indicated skin was to monitored routinely during care giving and problems identified would be documented. 3.1-37(a)		**="" b="">** **="" b="">** **="" b="">** **="" b<="" p="">**	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.			

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	(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on interview and observations, the facility failed to date open and/or prepare food products in the walk-in refrigerator. This deficient practices had the potential to aversively affect 34 of 34 residents who receive foods from the dietary department. Findings include: During an observation on 3/4/2024 at 6:50 p.m., three small bowls of prepared cottage cheese, a small bowl of prepared tomatoes, a plastic container of what Dietary Aide 2 identified as barbequed beef, a pitcher of orange liquid, and a cart with multiple glasses prepared with various drinks were all noted to not to be dated of when it was opened/prepared or with a use-by date. During an interview with Dietary Aide 2 on 3/4/2024 at 6:55 p.m., she indicated that they do not label the drinks on the cart because they "go through them so quickly." During an interview with the Dietary Manager on 3/5/2024 at 10:35 a.m., he indicated all 34 residents receive food from the kitchen and food items should be dated.	F 0812	F812 Food Procurement, Store/Prepare/Serve- Sanitary The facility does procure food from approved sources and stores/prepares and distributes in accordance with professional standards for food service safety. Noted items identified were removed from walk-in refrigerator and disposed. No resident was affected by alleged deficient practice. 100% audit of walk-in/freezer and dry storage areas was completed to ensure items were all appropriately dated. Dietary staff were re-educated relating to Food Storage Standards on 3/11/2024 Administrator or designee will audit all food storage areas for appropriate dating of food items 5 random times per week for 2 months then 3 times per week for additional 2 months to ensure ongoing compliance. Any negative finding will be presented to the facility QAPI.	04/03/2024

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	A policy entitled, "Food Storage Standards", was provided by the Clinical Operations Liaison on 3/6/2024 at 3:00 p.m. The policy indicated, " ...Ready-to-eat refrigerated foods are labeled according to FDA or state standards ..." A supportive documented to the policy, entitled "Food Storage Guide", was provided by the Clinical Operations Liaison on 3/7/2024 at 10:30 a.m. The guide indicated " ...Date food packages ..." 3.1-21(i)(3)		Compliance date 04/03/2024.	