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	04/05/2024

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/05/24 Facility Number: 001126 Provider Number: 155630 AIM Number: 200011300 At this Emergency Preparedness survey, Flatrock River Lodge was found in substantial 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 33. Quality Review completed on 04/17/24	E 0000		
E 0025 SS=C Bldg. --	403.748(b)(7), 418.113(b)(5), 441.184(b)(7), 482.15(b)(7), 483.475(b)(7), 483.73(b)(7), 485.625(b)(7), 485.920(b)(6), 494.62(b)(6) Arrangement with Other Facilities §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Leah Staley Hillenburg	HFA	05/02/2024

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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	section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents in	E 0025	Facility does have emergency preparedness policies and procedures that include arrangements with other LTC facilities and other providers to receive residents to maintain continuity of services.	05/10/2024

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	accordance with 42 CFR 483.73(b)(7). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Director and Acting Administrator on 04/05/24 between 10:00 a.m. and 12:25 p.m., development of arrangements with other facilities and other providers to receive residents in the event of limitations or cessation of operations was available for review but the Hospital agreement was dated from 2012. At the exit, the Corporate COO stated she was unaware of the requirement to update the agreements regularly. This finding was acknowledged by the Maintenance Director and Acting Administrator at the time of discovery and again at the exit conference with the Maintenance Director, Acting Administrator and Corporate COO all present.		Hospital agreement indicated in 2567 was reviewed and remains active. No residents were impacted by this alleged deficient practice. Related agreements to be reviewed annually with current emergency preparedness policies and procedures and updates made if indicated. Administrator will review annually with current emergency preparedness policies and procedures. Administrator or designee will review agreement arrangements monthly for 3 months to ensure ongoing compliance. Any negative findings will be reported to facility QAPI.	
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: 04/05/24 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 and executed solely because the provisions of Federal and State law require it. The facility maintains that the alleged deficiencies do not individually or	

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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 33 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 04/17/24		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.	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility	K 0271		05/10/2024

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	failed to ensure 1 of over 4 exit discharges had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect 12 residents and staff using 200 Hall Exit. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) and Acting Administrator on 04/05/24 between 12:25 p.m. and 2:00 p.m., the exit discharge from the 200 Hall Exit, had a rise in the concrete where the landing met the sidewalk and was uneven. A rubber or plastic ramp, measuring approximately 2 feet in width was being used to fill in the rise. The MD acknowledged that the walkway was in need of repair to have a complete level walking surface that was free of obstructions leading to the common way. This finding was acknowledged by the Maintenance Director and Acting Administrator at the time of discovery and again at the exit conference with the Maintenance Director, Acting Administrator and Corporate COO all present. 3.1-19(b)		Facility does routine walking rounds and had been monitoring walking surface change. Threshold type outdoor ramp has been was in place securely to concrete walkway at 200 hall and width of ramp was increased to fill rise. All exits have been checked and walkway to ensure free of uneven surfaces with no others issues identified. Maintenance Director or designee will verify exit discharge walking surfaces remain free of obstruction including uneven surfaces weekly for 8 weeks then monthly for additional 2 months to ensure ongoing compliance. Any negative finds will be reported to facility QAPI.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system			

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	option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 5 residents, as well as staff and visitors in the Activities Area. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) and Acting Administrator on 04/05/24 between 12:25 p.m. and 2:00 p.m., the Activities	K 0321	Facility planned storage areas do have appropriate locking and self-closure devices. The identified room had self-closing devices applied to door while temporarily being utilized for storage. Walk through by Maintenance Director did not identify any other areas. Maintenance Director or designee will observe rooms in facility weekly for self-closing door device in any area utilized for storage x 8	04/17/2024

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	Office, greater than 50 square feet contained a number of combustible items, such as, paper, plastic, and cardboard boxes. The corridor door to this office suite did not self-close and latch into the door frame. This finding was acknowledged by the Maintenance Director and Acting Administrator at the time of discovery and again at the exit conference with the Maintenance Director, Acting Administrator and Corporate COO all present. 3.1-19(b)		weeks, then monthly for 2 additional months to ensure ongoing compliance. Any negative findings will be reported to facility QAPI.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25,	K 0353	Facility has had routine sprinkler system monitoring in addition to regular inspection with maintenance by vendor. Maintenance Director addressed	05/10/2024

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	Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, 5.2.2.2 requires sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) and Acting Administrator on 04/05/24 between 12:25 p.m. and 2:00 p.m., the attic in the corridor near and above RR#403 had wire draped across the sprinkler pipe. This finding was acknowledged by the Maintenance Director and Acting Administrator at the time of discovery and again at the exit conference with the Maintenance Director, Acting Administrator and Corporate COO all present. 3.1-19(b)		identified wires draped over sprinkler pipes immediately by securing placement above/off of pipes. Other areas in ceiling-attic checked and addressed if indicated. Maintenance Director reviewed inspection requirements related to items draped on sprinkler pipes in attic. He acknowledges requirement and that he will after vendor visit verify items not draped on sprinkler pipes in areas that were accessed. Maintenance Director to verify after vendor visit that sprinkler pipes remain free of items draped or placed on them and randomly each month for 3 months to ensure ongoing compliance. Any negative findings will be reported to facility QAPI.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by			

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	CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	1. Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 2 staff. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) and Acting Administrator on 04/05/24 between 12:25 p.m. and 2:00 p.m., the corridor door	K 0363	Facility does ensure corridor doors close without impediment to reduce risk of smoke. Identified doors were not in resident areas. Office door was immediately adjusted to ensure latched each time with closure. Dietary hall door was closed and staff immediately educated on not using door stop of any device. Walk through did not identify any other door with concern.	04/17/2024

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	to the "Office" equipped with a self-closing device, failed to close and latch positively into the door frame. Based on interview at the time of the observations, the MD agreed the aforementioned corridor door did not close and latch into the door frame and would not resist the passage of smoke. This finding was acknowledged by the Maintenance Director and Acting Administrator at the time of discovery and again at the exit conference with the Maintenance Director, Acting Administrator and Corporate COO all present. 2. Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 5 staff. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) and Acting Administrator on 04/05/24 between 12:25 p.m. and 2:00 p.m., the corridor door to the kitchen in the dietary hall was propped open with cardboard fashioned as a doorstop. Based on interview at the time of observation, MD acknowledged the aforementioned corridor door would not close unless the cardboard doorstop was moved first. This finding was acknowledged by the Maintenance Director and Acting Administrator at the time of discovery and again at the exit conference with the Maintenance Director, Acting Administrator and Corporate COO all present.		All staff were provided education regarding corridor doors and related requirements on 4/17/24. Maintenance Director or designee will observe doors in facility weekly for latch with closure and no use of door stop type device to that may prevent closure for 8 weeks, then monthly for 2 additional months to ensure ongoing compliance. Any negative findings will be reported to facility QAPI.	

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K 0761 SS=E Bldg. 01	3.1-19(b) Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of at least 1 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.	K 0761	Facility does maintain and inspect doors as part of preventative maintenance program. Identified fire door does have rating listed and labeled accordingly. It has been component of preventative maintenance in relation to door inspections and will continue with added documentation. Inspection completed and documented on 04/29/24. No other door requires Annual Fire door inspection at this time. Maintenance Director reviewed training online related to inspection, documentation and testing of Fire doors. Administrator or designee will review maintenance documentation monthly for 3 months to ensure ongoing compliance. Any negative findings will be reported to facility QAPI.	04/29/2024

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	(4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect 20 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) and Acting Administrator on 04/05/24 between 12:25 p.m. and 2:00 p.m., no documentation of an annual inspection for the fire door assembly at the Oxygen Transfilling room was available for review. Based on observation during the tour the Oxygen Transfilling room has one 90-minute fire door assembly. Based on interview at the time of records review and observation, no documentation was available for an annual fire door inspection completed within the last year. This finding was acknowledged by the Maintenance Director and Acting Administrator at the time of discovery and again at the exit conference with the Maintenance Director, Acting Administrator and Corporate COO all present.			

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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
	3.1-19(b)			