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	03/03/2021

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 the Investigation of Complaints IN00345736, IN00346831 and COVID-19 Focused Infection Control Survey. This visit included a Residential COVID-19 Quality Assurance Walk Through Survey. Complaint IN00345736 - Substantiated. Federal/State deficiencies related to the allegations are cited at F880 and F842. Complaint IN00346831 - Substantiated. Federal/State deficiencies related to the allegations are cited at F880 and F842. Survey dates: March 2 and 3, 2021 Facility number: 001126 Provider number: 155630 AIM number: 200011300 Census Bed Type: SNF/NF: 38 Residential: 4 Total: 42 Census Payor Type: Medicare: 4 Medicaid: 29 Other: 5 Total: 38 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 9, 2021	F 0000	Plan and execution of the plan of correction for the survey does not constitute admission of agreement by this provider of the truth of facts alleged or the conclusion set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by Federal and State law. This provider maintains that the alleged deficiency does not individually or collectively jeopardize the health and safety of its residents; nor are they of such character as to limit the provider's capacity to render adequate resident care. This plan of correction serves as the facility's written credible allegation that it will be in substantial compliance on or before 04/02/21. Flat Rock River Lodge respectfully requests that a "desk" review be conducted and accepted. Additional documentation will be sent upon request.	

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

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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F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral			

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	directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on observation, interview and record review, the facility failed to accurately and completely document the bathing and hygiene care and services of 3 of 3 residents reviewed for activities of daily living (ADL's), specific to bathing and hygiene. (Residents B, C and D) Findings include:	F 0842	**F 842 Medical Records** The facility does maintain Medical Records in accordance with accepted professional standards and practices. Facility had identified that previous management staff did not utilize provided process regarding documentation specific to C.N.A.	03/29/2021

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	1. The clinical record of Resident B was reviewed on 3-2-21 at 2:15 p.m. Her diagnoses included, but were not limited to, hypertension, chronic obstructive pulmonary disease and heart failure. Review of her most recent Minimum Data Set (MDS) analysis, dated 1-7-21, indicated she had severe cognitive impairment, was independently ambulatory, required limited assistance of 2 or more assistance with hygiene, extensive assistance of 1 person for bathing and limited assistance of 1 person for dressing. Review of the facility's "CNA Shower Schedule" indicated Resident B was scheduled to receive showers on Wednesdays (W) and Saturdays (Sa) during the evening shift. This document indicated, "CNA's must complete a shower sheet for all showers!! If a resident refuses a shower the nurse must be notified and documentation completed. Nail care must be completed on all residents and documented. All male residents have to be shaved." A handwritten date of "1-7-21" was located on the upper left-hand side of the document. Review of Resident B's "Skin and Body Assessment," and informally referred to as, "Shower Sheets" for the time period of 1-6-21 to 3-2-21, indicated Resident B had this form utilized only on 1-6-21 (W) (twice), 1-13-21(W), 1-16-21 (Sa), 1-20-21 (W), 1-23-21(Sa), 1-27-21(W), 2-3-21 (W), 2-6-21(Sa), 2-17-21(W), and 2-24-21(W). 11 of 11 of the "Skin and Body Assessment," forms failed to identify if the resident actually received any type of bathing services. The form had a hand-written area to identify if nail care or shaving occurred, with 7 of 11 forms failing to indicate if nail care had been provided. 4 of 11 forms failed to indicate if shaving care had been provided. Computerized documentation of ADL's, specific to		assignment and cares. 1. Residents B, C, and D were assessed on 03/02/20 with no evidence of missed shower or bath “no body odor, skin concerns or unkept appearance. 2. All residents were interviewed regarding their preferences related to bathing as well as if they had any concerns with receiving their bath/showers. Shower list and care plans were updated to reflect if requested any change in preference regarding schedule. 3. CNA staff provided in service on importance of proper and timely documentation as well as communicating care not provided on assignment sheet as well as to Nurse who will then carry over to 24-hour report. Licensed Staff provided in service on 24-hour report so next shift can provide cares as well as review of timely documentation of refusals of care related to ADL’s specific to Bathing and Hygiene (Attachment 1 4. DON or designee will audit C.N.A. assignment, 24-hour report sheets and Electronic Health Record to ensure timely and proper documentation has been completed 5 days weekly for 4 weeks, then 4 days weekly for 4 weeks, then 3 days weekly for 4 weeks, then weekly for 12 weeks. Findings will be reported to QAPI	

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	bathing and hygiene services for the time period of 1-15-21 to 3-2-21 indicated hygiene services were documented only on the evening shift on 1-15-21, 1-27-21 2-17-21 and 2-20-21. Both types of documentation failed to ensure documentation was completed on a daily basis. Both types of documentation and nursing progress notes failed to identify any dates of refusal of care. 2. The clinical record of Resident C was reviewed on 3-2-21 at 1:10 p.m. His diagnoses included, but were not limited to, intracranial injury, pneumonia, sepsis, hypotension, cerebral infarction, metabolic encephalopathy, dysphagia and general muscle weakness. Review of his most recent Minimum Data Set (MDS) analysis, dated 2-7-21, indicated he was cognitively intact, non-ambulatory and required the use of a wheelchair for mobility, dependent of 1 person for hygiene and bathing care and required extensive assistance of 1 person for dressing. Resident C was hospitalized and out of the building on the dates of 1-27-21 until 1-31-21. Review of the facility's "CNA Shower Schedule," indicated Resident C was scheduled to receive showers on Tuesdays (Tu) and Fridays (F) during the day shift. This document indicated, "CNA's must complete a shower sheet for all showers!! If a resident refuses a shower the nurse must be notified and documentation completed. Nail care must be completed on all residents and documented. All male residents have to be shaved." A handwritten date of "1-7-21" was located on the upper left-hand side of the document. Review of Resident C's "Skin and Body Assessment," and informally referred to as, "Shower Sheets" for the time period of 1-1-21 to		committee along with Findings/Progress related to Performance Improvement Project related to Documentation. Completion date 03/29/2021	

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	3-2-21, indicated Resident C had this form utilized only on 1-1-21 (F), 1-5-21 (Tu), 1-8-21 (F), 1-15-21(F), 2-2-21(Tu) and 2-5-21(F). to identify if the resident actually received any type of bathing services. Five of 6 of the "Skin and Body Assessment," forms failed to identify if the resident received any type of bathing. Five of 6 of the "Skin and Body Assessment," forms had a hand-written area to identify if nail care or shaving occurred. Two of 6 forms failed to indicate if nail care had been provided. Two of 6 forms failed to indicate if shaving care had been provided. Computerized documentation of ADL's, specific to bathing and hygiene services for the time period of 1-15-21 to 3-2-21 indicated hygiene services were only documented for the day shift on 2-3-21 and for the evening shift of 1-15-21, 2-17-21, 2-20-21, 2-25-21 and 3-1-21. Both types of documentation failed to ensure documentation was completed on a daily basis. Both types of documentation and nursing progress notes failed to identify any dates of refusal of care. 3. The clinical record of Resident D was reviewed on 3-2-21 at 4:10 p.m. Her diagnoses included, but were not limited to, type 2 diabetes, hypertension, chronic obstructive pulmonary disease, nonrheumatic aortic valve disorder, morbid obesity, unsteadiness on feet and a recent history of Covid-19. Review of her most recent Minimum Data Set (MDS) analysis, dated 2-17-21, indicated she was cognitively intact, non-ambulatory and required the use of a wheelchair for mobility, required extensive assistance of one person for hygiene care, bathing care and dressing. Review of the facility's "CNA Shower Schedule," indicated Resident D was scheduled to receive showers on Tuesdays (Tu) and Fridays (F) during the day shift. This document indicated, "CNA's			

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	must complete a shower sheet for all showers!! If a resident refuses a shower the nurse must be notified and documentation completed. Nail care must be completed on all residents and documented. All male residents have to be shaved." A handwritten date of "1-7-21" was located on the upper left-hand side of the document. Review of Resident D's "Skin and Body Assessment," and informally referred to as, "Shower Sheets" for the time period of 1-1-21 to 3-2-21, indicated Resident D had this form utilized only on 1-1-21 (F), 1-5-21 (Tu), 1-29-21 (F), and 2-2-21 (Tu). 1 of 4 of the "Skin and Body Assessment," forms failed to identify if the resident actually received any type of bathing services. Three of 4 forms indicated the resident had no new skin issues and 1 of 4 indicated she had new open areas to her abdominal area. The form had a hand-written area to identify if nail care or shaving occurred. Two of 4 forms failed to indicate if nail care had been provided. Four of 4 forms indicated shaving care had not been provided and 2 of 4 failed to acknowledge if shaving services had or had not been provided. Computerized documentation of ADL's, specific to bathing and hygiene services for the time period of 1-15-21 to 3-2-21 indicated hygiene services were only documented for the day shift on 2-17-21, on the evening shift on 1-15-21, 1-27-21, 2-17-21 and 2-20-21, and on the night shift on 1-23-21 and 1-25-21. Both types of documentation failed to ensure documentation was completed on a daily basis. Both types of documentation and nursing progress notes failed to identify any dates of refusal of care. On 3-3-21 at 1:32 p.m., an observation was made of a binder, entitled "CNA Binder", located at the			

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	nurse's station desk ledge, located in public view. On the front of the binder was a notation which indicated, "Shower schedule was updated 1-7-21. Please review. Shower refusals must be approved by nurse. Fill out a shower sheet for EVERY resident on their scheduled shower day and write on it what was done [bed bath, refused, shower, etc.] [sic]". This document was undated as to when it was placed on the binder. In an interview on 3-3-21 at 1:25 p.m., with QMA 2, she indicated the aide staff are to complete a shower sheet ("Skin and Body Assessment"), for any resident who receives a shower, bed bath or complete bath. The person who performed the shower is to then place the form in the mailbox of the Director of Nursing (DON). She indicated the aide staff typically do not complete the computerized documentation of ADL's. In an interview on 3-3-21 at 3:35 p.m., with Corporate Administrator 4, she indicated the facility had recently discovered the former DON was not utilizing the approved corporate paperwork for the CNA's to utilize for CNA assignments and documentation of bathing and hygiene services, as well as other ADL services. On 3-3-21 at 3:35 p.m., Corporate Administrator 4 provided a copy of a protocol entitled, "Assignments, C.N.A.," with a revision date of 11/2020. It indicated, "Purpose: To ensure that direct care giving staff members have the information required to carry out their job while following daily work assignments, and that information is communicated appropriately to all facility staff. Protocol: C.N.A. assignments are part of the resident's care plan and are prepared and reviewed by a licensed nurse and are issued on a daily basis. C.N.A. Assignment sheets			

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	should be printed for the day after changes made from morning meeting. The responsible C.N.A. is required to sign-off on the completion of their assignments at the end of their shift, thereby agreeing that all care was provided/completed according to the resident's care plan. Resident refusals will be communicated to the charge nurse for carry over to the 24-Hour report so the next shift can provide the cares...The following information should be considered for inclusion on the sheets...Bathing: Include preferred method of bathing [i.e., bed bath, whirlpool, shower], any specialty equipment or products required, level of assistance, days/shifts bathing is scheduled, finger/toenails trimming by aides or nursing [nurses trim diabetic resident nails], shaving [body parts/frequency]." This Federal tag relates to Complaints IN00345736 and IN00346831. 3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(a)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following			

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	elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be			

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	followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview and record review, the facility failed to properly prevent and/or contain COVID-19 by touching PPE (personal protective equipment) of facial coverings (masks) repeatedly while in use and wearing masks in a manner to cover nose and mouth. This action has the potential to affect all 42 residents of the facility. Additionally, the facility failed to ensure staff do not place soiled linens onto the floor prior to bagging the soiled linens for 1 of 2 residents observed for care. (Resident D, QMA 2 and CNA 3) Findings include: 1. During care observations of Resident C and Resident D on 3-3-21 between 1:15 p.m. and 1:45 p.m., CNA 3 was observed to adjust her N-95 mask multiple times with gloved and ungloved hands, by holding onto the front portion of the mask, not at the side portion of the mask. Use of hand hygiene, with the use of alcohol-based hand	F 0880	**DPOC F880 Infection Prevention & Control** The facility does have and maintains an infection prevention and control program that is designed to provide a safe, sanitary and comfortable environment to prevent the development and transmission of communicable diseases and infections including COVID-19. 1. Neither resident C or D was found to have been affected by the alleged deficient practice. C.N.A.3 along with C.N.A. /Licensed Nurses were provided education on donning/doffing of PPE as well as soiled linen management immediately. 2. Other residents residing in the facility have the potential to be affected by the alleged deficient practice. Rounds were made to	03/29/2021

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	rub or handwashing, was not observed after each incidence of touching of the face mask. One observation was made of the N-95 mask of CNA 3 in which the mask was below her nose and she promptly readjusted the mask to cover her nose by holding onto to the front portion of the mask. 2. During a care observation of Resident D on 3-3-21 between 1:35 p.m. and 1:45 p.m., with QMA 2 and CNA 3, CNA 3 was observed to remove a soiled incontinence pad from under Resident D, fold it in half, with the soiled portion on the inside aspect, and place it on the floor. Upon completion of the care, she was observed to transport the soiled linen into the bathroom and place it into a clear bag. In interview with QMA 2 at this time, she indicated all used or soiled linen should be immediately bagged. In interview with CNA 3 at this time, she indicated she has worked at the facility for only a few weeks but has been a CNA for over 5 years. In interview with the Administrator on 3-3-21 at 2:35 p.m., she indicated the facility follows all regulations for COVID-19 related infection control issues as put forth by the CDC (Centers for Disease Control) and the State's Standard Operations Procedures. She indicated she could not readily locate specific policies on placing soiled linen on the floor but would continue to look for this. She indicated placing soiled linen was not an acceptable practice of the facility. On 3-3-21 at 3:35 p.m., Corporate Administrator 4 provided an undated copy of a procedure titled, "Guidelines: Handling Equipment, Linen, and Clothing." It indicated, "Bag soiled linen at point of origin." "Contingency Capacity Strategies", (11-23-2020)		ensure proper donning and doffing of PPE were occurring, contaminated PPE was cleaned and stored or discarded appropriately, and hand hygiene was performed at the appropriate times. The residents who were residing on the yellow zone during this survey had no development of Covid-19 symptoms and have since been moved to the green zone or discharged per their plan of care. 3. The facility LTC Infection Control Self-assessment was reviewed and updated (Attachment 3A – 3F) · Root Cause Analysis (RCA) was completed (Attachment 4A – 4B) Involved staff were educated regarding the correct sequencing of donning and doffing PPE, with return demonstrations including masks, gloves, guidance (Attachment 5A – 5C) . 4. The facility will monitor the corrective action by implementing the following measures: The IP/DON or designee will observe the staff to ensure proper donning and doffing sequencing and techniques are performed across all shifts, 5 days of week for 4 weeks, then weekly for 8 weeks, then monthly for 3 months for a total of 6 months of monitoring using the attached audit tool (attachment 6) and gown and eye protection utilizing	

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	03/03/2021

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	was retrieved on 3-4-21 from the Centers for Disease Control (CDC) website. The guidance included the following information regarding the use of facial coverings: "Extended use of facemasks is the practice of HCP [healthcare personnel] wearing the same facemask as PPE [e.g., for patients on Droplet Precautions] during encounters with several different patients, without removing the facemask between encounters...HCP must take care not to touch their facemask. If they touch or adjust their facemask, they must immediately perform hand hygiene..." This Federal tag relates to Complaints IN00345736, IN00346831 and COVID-19 Focused Infection Control Survey. 3.1-18(b)		CDC The IP/DON or designee will observe the staff to ensure proper linen management is performed across all shifts ,5 days week for 4 weeks, then weekly for 8 weeks, then monthly for 3 months for a total of 6 months of monitoring using the attached audit tool (Attachment 7). The IP/DON or designee, will observe the staff for effective completion of hand hygiene 5 days a week for 4 weeks, then weekly for 8 weeks, then monthly for 3 months for a total of 6 months of monitoring using the attached audit tool.(Attachment 8) . The results of these reviews will be reported to QAPI Substantial Compliance by 03/29/2021	
R 0000 Bldg. 00	This visit was for a Residential COVID-19 Quality Assurance Walk Through Survey. This visit included the Investigation of Complaints IN00345736, IN00346831, and COVID-19 Focused Infection Control survey. Complaint IN00345736 - Substantiated. Federal/State deficiencies related to the allegations are cited at F880 and F842.	R 0000	Plan and execution of the plan of correction for the survey does not constitute admission of agreement by this provider of the truth of facts alleged or the conclusion set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by Federal and State law. This provider maintains that the alleged deficiency does not	

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	Complaint IN00346831 - Substantiated. Federal/State deficiencies related to the allegations are cited at F880 and F842. Survey dates: March 2 and 3, 2021 Facility number: 001126 Residential Census: 4 Flatrock River Lodge was found to be in compliance with 410 IAC 16.2-5 in regard to the Residential COVID-19 Quality Assurance Walk Through. Quality review completed on March 9, 2021		individually or collectively jeopardize the health and safety of its residents; nor are they of such character as to limit the provider's capacity to render adequate resident care. This plan of correction serves as the facility's written credible allegation that it will be in substantial compliance on or before 04/02/21. Flat Rock River Lodge respectfully requests that a "desk" review be conducted and accepted. Additional documentation will be sent upon request.	