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	01/10/2023

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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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: January 3, 4, 5, 6, 9 & 10, 2023 Facility number: 001126 Provider number: 155630 AIM number: 200011300 Census Bed Type: SNF/NF:35 Residential: 1 Total: 36 Census Payor Type: Medicare: 4 Medicaid: 24 Other: 7 Total: 35 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 13, 2023	F 0000	Flatrock River Lodge respectfully requests desk review for the following alleged deficiencies. This plan of correction is to serve as Flatrock River Lodge's credible allegation of compliance on 1-27-23. Submission of this plan of correction does not constitute an admission by Flatrock River that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Neither does this submission constitute an agreement or admission of the survey allegations.	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.	F 0558	The facility does provide residents with reasonable accommodation	01/23/2023

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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	Based on observation, interview, and record review, the facility failed to ensure a resident's fluids were in reach for 4 of the 6 survey days. This affected 1 of 1 resident reviewed for accommodation of needs. (Resident 9) Findings include: During an observation, on 1/04/23 at 10:59 a.m., Resident 9 did not appear to be dehydrated, but her water was on the bedside table at the end of her bed, out of reach. On 1/5/23, at 9:50 a.m., Resident 9 was lying in bed, eyes closed, her water pitcher was on her over bed table out of her reach. On 1/6/23, at 2:41 p.m., Resident 9 was in bed, eyes closed, her water pitcher was on her over bed table out of her reach, about 3 feet from the side of her bed. On 1/9/23, at 10:07 a.m., Resident 9 was in bed, her water pitcher was out of reach on her over bed table. Resident 9's record was reviewed on 1/9/23 at 11:45 a.m. and indicated diagnoses, that included, but were not limited to, generalized muscle weakness, high blood pressure, age related physical debility, disorientation, osteoporosis, pain, Alzheimer's disease late onset, and dementia without behaviors, psychosis, mood or anxiety. An Annual Minimum Data Set assessment, dated 10/4/22, indicated Resident 9 was severely impaired in cognitively skills for daily decision making, and eating was extensive assist of one. Current physician's orders for fluids indicated an		to meet their needs/preferences. Resident 9 was provided item to place fluids/personal items in reach and the care plan has been updated to identify need for device when in low bed. There were no adverse effect related to allegation as staff were offering fluids with cares due to inconsistent effort usually dependent resident to self-initiate picking up cup for fluids. Residents requiring use of low bed identified, record reviewed and care observed. Care plans updated if needed. Resident Rights training assigned and completed on line for staff. New hires receive Resident Rights training during orientation. Reeducation specific to low bed and items in reach conducted with staff in 1-1 or small group setting. Social Service employee or designee will make 5 observations of residents in low beds access to fluids daily x 4 weeks then, 5 observations weekly for 8 weeks. Negative findings will be reported to facility QAPI committee. Compliance 1/23/23	

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	order dated 2/24/21 to encourage fluids with assistance, 240 milliliters three times a day/evening a.m. and p.m. and to monitor intake and output every a.m., p.m., and night with nights obtaining a 24 hour intake. 1/10/23 at 12:20 a.m., Resident 9 was sitting in the dining room eating and drinking independently. Interview with CNA 3 indicated the resident does feed herself and drink independently, that sometimes she starts out feeding herself and at the end of the meal staff will have to help her. She said the resident has good days and bad days. A Policy for "Hydration Management" was provided by the Administrator on 1/10/23 at 3:25 p.m. The policy included, but was not limited to, "Purpose: Hydration management will be accomplished through an individualized plan to promote adequate hydration based on risk factor identification and assessment and to determine if intake and/or output monitoring is indicated...3. Fluids will be provided consistently throughout the day...." 3.1-3(v)(1)			
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including			

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	sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on interview and record review, the facility failed to ensure a resident's choice for shower times was honored. This affected 1 of 1 resident reviewed for choices. (Resident 30) Findings include: During an interview, on 1/03/23 at 12:49 p.m., Resident 30 indicated she didn't get her bath when she wants it, she prefers during the day and gets a shower on second shift around 9:30 - 10:00 p.m. On 1/09/23, at 1:58 p.m., Resident 30 was lying in bed dressed in street clothes and said she still prefers to have a shower during the day. Resident 30's record was reviewed on 1/5/23 at 12:59 p.m. The record indicated diagnoses that	F 0561	The facility does provide resident opportunities related to self-determination. Resident 30 was interviewed by Director of Nursing 1/10/23 with care plan updates made to reflect her preferences. Other residents and or family member, if appropriate, were interviewed to ensure bathing/shower preferences were identified and noted in careplans. Resident Rights training assigned and completed on line for staff. New hires receive Resident Rights training during orientation. Reeducation specific to	01/13/2023

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	included, but were not limited to, repeated falls, altered mental status, high blood pressure, anxiety, depression, and vascular dementia. An Annual Minimum Data Set assessment, dated 4/22/22, indicated Resident 30 was cognitively intact, speech was clear, and had no moods or behaviors. A Quarterly Minimum Data Set (MDS) assessment, dated 11/28/22, indicated Resident 30 was cognitively intact, speech was clear, makes self understood, understands others, and had no behaviors. An Annual MDS, dated 4/22/22, indicated Resident 30 was cognitively intact, speech was clear, makes self understood and understands others, and had no behaviors. A data collection tool, for preferences for customary routine and activities had not been filled out, and had no date. On 1/10/23 at 12:18 p.m., the Activity Director indicated the above form was one of two they used, on admission and once a year after that. She said she usually only keeps one copy in the book, and the assessment had been pulled and not turned back in. She said Resident 30 likes to take a shower but wasn't specific on the time, that in the past she told her she didn't care when she got one as long as she got one. She said she would fill out another assessment and place it in her book, which she did and provided a copy of it. A Policy for "Resident Personal Hygiene and Cares" was provided by the Administrator on 1/10/23 at 3:25 p.m. The policy indicated, but was not limited to, "Purpose: To provide uniform		bathing/shower preferences with discussion to be held during individuals RAI process or if requested at any time with the IDT. MDS nurse or designee will interview residents or family member, if appropriate, during quarterly careplan meeting for 6 months to ensure any bathing/shower preferences are careplanned. Negative findings will be presented to facility QAPI committee. Compliance 01/13/2023	

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	guidance to C.N.A's on standard hygiene and personal care tasks for residents that comprise AM and HS cares and the bathing/showering process...4. Bathing/Showering Process: a. Upon admission to the nursing home, a resident preference interview will be completed with regard to preferred bathing method, frequency and time of day. b. The C.N.A. assignment sheet will be updated to include the information in the Bathing column of the C.N.A assignment sheet...." 3.1-3(a)			
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. Based on interview and record review the facility failed to notify the physician of low and high blood sugars and failed to assess the resident for hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) for 1 of 5 residents reviewed for unnecessary medication (Resident 1). Finding include: Review of the record of Resident 1 on 1/6/23 at 10:21 a.m., indicated the resident's diagnosis included, but were not limited to, diabetes mellitus.	F 0684	Facility does ensure residents receive treatment and care in accordance with professional standards of practice. Resident 1's physician was advised of blood sugar readings dated 11/18/22, 11/25/22 and 12/6/22 with no changes in orders. Nurses providing Care that obtained readings were counselled and reeducation provided. All other residents with ordered blood sugar readings outside	01/23/2023

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	The physician order for Resident 1, dated January 2023, indicated the resident was ordered levemir (insulin) 52 units in the morning and at night. The physician order indicated if the resident's blood sugar (BS) was below 70 or above 400 the physician was to be notified. Review of Resident 1's blood sugar, dated 11/18/22 was 50, 11/25/22 was 454 and 12/6/22 was 58. During an interview with the Director Of Nursing (DON) on 1/9/23 at 2:49 p.m., indicated there was no documentation the physician was notified of Resident 1's blood sugars on 11/18/22, 11/25/22 or 12/6/22. There was no documentation of any assessment of Resident 1 for hyperglycemia or hypoglycemia symptoms in the resident's record. The DON provided a 24 hour report sheet, dated 12/6/22, with Resident 1's name on it and documentation of BS 58 orange juice given and rechecked and was 79. The diabetic blood sugar monitoring policy provided by the DON on 1/10/23 at 11:20 a.m., indicated hypo/hyperglycemic episodes will be reported and treated appropriately. Assess for symptoms of hypoglycemia. from milder, more common indicators to most severe, signs and symptoms of low blood sugar include: feeling shaky, being nervous/anxious, sweating, chills, clamminess, confusion, hast heartbeat, lightheaded, dizzy, hunger, nausea, pale skin, sleepy, feeling weak, blurred/impaired vision, tingling or numbness of lips, tongue and cheeks, headaches, coordination problems, nightmares or seizures. If a blood sugar are less than 70 recheck the blood sugar and notify the physician. Hold scheduled insulin/diabetic medication until the physician addresses. If the residents blood sugar		policy parameters were reviewed for prior 30 days with attending medical providers. Individualized notification parameters were ordered if applicable. Licensed nurses received reeducation related to diabetic management, physician notification specific to blood sugar readings. Newly hired licensed nurses receive training during orientation. Director of Nursing or designee will review nursing notes, 24-hour report sheet and medication and treatment administration records of diabetic residents for blood sugar readings outside notification parameters daily for 2 months then weekly for an additional 2 months to ensure appropriate documentation of notifications and interventions are in place. Negative findings will be submitted to QAPI committee. Compliance 01/23/2023	

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	is above 300 recheck the blood sugar and notify the physician. 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to utilize two staff for transfers for Resident 188, resulting in a fall, failed to use a gait belt during a transfer for Resident 188, failed to implement fall interventions for Resident 139, and failed to use a gait belt during a transfer for Resident 140. This affected 3 of 5 residents reviewed for accidents. (Residents 188, 139, and 140) Findings include: 1. During an interview, on 1/03/23 at 2:10 p.m., Resident 188 indicated she fell and hurt her left lower leg and cut a big gash in her left leg. Resident 188's record was reviewed on 1/04/23 at 3:11 p.m. and indicated diagnoses that included, but were not limited to, heart failure, atrial fibrillation, chronic obstructive pulmonary disease, with acute exacerbation, depression, and	F 0689	Facility does ensure resident environment is as free of accident hazards as is possible and they receive adequate supervision and assistance. Resident 188 did have reassessment of transfer ability as provided to surveyors. CNAs identified were counselled and provided reeducation with return competency observation. Resident 139 had IDT review of fall related risks and care plan including care assignment portion of careplan. Each was updated if needed with appropriate interventions applicable to their current stay. Resident 140 did have reassessment of transfer ability as provided to surveyors. CNAs	01/18/2023

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	asthma. An Admission Minimum Data Set assessment, dated 12/4/22, indicated Resident 188 was moderately impaired in cognitive skills for daily decision making, received hospice services, had a fall prior to admission, but none since admission, required extensive assistance of 2 for bed mobility, transfers, and toilet use, did not walk, balance was unsteady, she was only able to stabilize with staff assistance. A baseline care plan, dated 11/21/22, indicated Resident 188 was alert, occasionally confused, had a history of falls within the last 180 days, is a fall risk due to weakness, and was assist of one for transfers and toileting. Incident documentation of the fall, dated 12/15/22 at 8:40 p.m., indicated Resident 188 had been lowered to the floor on 12/15/22 at 6:00 p.m. She was in the bathroom and the activity at the time was transferring, the equipment involved was a wheelchair. The injury was a skin tear on the left leg 5 centimeters by 0.5 centimeters. A follow up of incident dated 12/19/22, indicated the resident had a laceration of her left lower leg, she was being toileted by a CNA and her knees became weak and she had to be sat on the floor. A second CNA came to assist the resident up and cut resident's leg on the foot pedal of her wheelchair. First aid was applied and hospice was called. The Interdisciplinary Team had updated the care plan and made the resident an assist of 2. On 1/06/23 at 9:39 a.m., the Director of Nursing indicated Resident 188 was being toileted with one person assist, she had to lower her to the floor then she got assistance to get her up. When		identified were counselled and provided reeducation with return competency observation. All other residents requiring assistance with transfers careplans were reviewed to and updated if needed. CNA's have received reeducation and return competency verified in regards to transfers. Management Nurses and IDT received re-education specific to care plan updates specific to current stay. HFA or designee will review care plans of new admissions in addition to observation of 2 random transfers weekly for 4 weeks then monthly x 3months. Negative findings will be reported to facility QAPI committee. Compliance 01/18/23	

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	they were helping her stand, her leg was cut on her wheelchair. This happened on 12/15/22. The new intervention was to have her be a two person assist. On 1/10/23 at 1:18 p.m., Resident 188 was observed as she was transferred from her wheelchair her recliner chair with CNA 3 and CNA 4. CNA 4 took the resident's catheter drainage bag and hooked it to her front pocket, both CNA's took hold of her arms and helped the resident to stand, then sat her back down in her wheelchair. The Director of Nursing then instructed the CNA's to use a gait belt and let the resident hold the catheter drainage bag. They placed the gait belt around the resident's waist and stood her up, then pivoted her into the recliner. 2.) During an observation on 1/3/23 at 12:50 p.m., Resident 139 was in his room sitting in a wheelchair watching TV, there was no staff present. The resident did not have an alarm on his wheelchair or bed. During an observation on 1/4/23 at 1:50 p.m., , Resident 139 was in his room sitting in a wheelchair watching TV, there was no staff present. The resident did not have an alarm on his wheelchair or bed. During an observation on 1/5/23 at 1:38 p.m., Resident 139 was in his room sitting in a wheelchair watching TV, there was no staff present. The resident did not have an alarm on his wheelchair or bed. During an observation and interview on 1/6/23 at 2:42 p.m., with the Director Of Nursing (DON) Resident 139 was laying in bed. The DON verified the resident had no alarm on his bed or wheelchair. The DON indicated she not aware that the resident had been left in his room alone in his			

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	wheelchair. Review of the record of Resident 139 on 1/5/23 at 1:20 p.m., indicated the resident's diagnoses included, but were not limited, reduced mobility, dehydration, kidney disorder, age related physical debility, atrial fibrillation, dementia, fall, diabetes, weakness and heart failure. The Admission Minimum Data Set (MDS) assessment for Resident 139, dated 12/18/22, indicated the resident was severely cognitively impaired for daily decision making. The resident required extensive assistance of two people to transfer. The resident did not ambulate. The resident used a wheelchair as a mobility device. The resident had a fall in the last month and a fracture from a fall in the pas six months prior to admission. The plan of care for Resident 139, dated 1/4/23, indicated the resident had the potential for falls related unsteady gait and weakness. The interventions included, but were not limited to, chair alarm on when in the chair and bed alarm. The special care remarks indicated the resident was not to be left in his wheelchair in his room alone. The fall risk assessment for Resident 139, dated 1/3/22, indicated the resident was incontinent, received a hypnotic that could contribute to falls, the resident was unable to ambulate and used a wheelchair as a mobility device The incident report for Resident 139, dated 12/19/22, indicated the resident was found on the floor in his room. The resident had been moving around in bed. The resident had an abrasion 4 cm by 6 cm (no location)(right knee). Neurological			

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	assessment completed. The immediate intervention was the resident's bed in the lowest position. The incident report for Resident 139, dated 1/3/22 at 4:20 p.m., indicated the resident was found on the floor. The resident had been in bed resting. No apparent injury. 3.) During an observation on 1/4/23 at 1:54 p.m., CNA 1 and CNA 2 transferred Resident 140 from the wheelchair to the toilet by holding her underneath her arms and the back of her pants, no gait belt was used. CNA 1 and CNA 2 transferred the resident from the toilet to the wheelchair by holding her underneath her arms and the back of her brief, there was no gait belt used. The resident was unable to assist with the transfer and was totally dependent on staff for the transfer. During an interview with Resident 140's family member on 1/5/23 at 12:49 p.m., indicated the resident had not been at the facility long. The reason Resident 140 came to the facility was because she fell at home and broke her clavicle. During an interview with the DON on 1/10/23 at 10:16 a.m., indicated the protocol was staff were to use a gait belt when transferring Resident 140. The safe resident handling and mobility program provided by the Administrator on 1/10/23 at 10:25 a.m., indicated the facility would train staff in the use of a gait belt with transfers. Review of the record of Resident 140 on 1/10/23 at 1:07 p.m., indicated the resident's diagnoses included, but were not limited to, fracture of the right clavicle, right hip contusion, heart failure, unspecified fall, age related debility, diabetes,			

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	atrial fibrillation, anxiety disorder, osteoporosis and chest pain. The Admission Minimum Data Set (MDS) assessment for Resident 140, dated 1/4/23, indicated the resident was moderately impaired for daily decision making. The resident required extensive assistance of two people for transfers and did not ambulate. The resident had a fall in the last month prior to admission. The fall assessment for Resident 140, dated 12/28/22, indicated the resident had 4 diagnoses that contributed to falls, had a history of falls, fell at home and broke her right clavicle, required cueing when to turn around and sit down, used a walker/wheelchair for mobility, had a decline in her functional status in the last 90 days and wears glasses. The fall care plan for Resident 140, dated 1/3/23, indicated the resident had potential for falls related to unsteady gait manifested by history of falls, unsteady gait (or near fall) in the last 180 days and recent hospital stay. The intervention included, but were not limited to, call light in reach, encourage to ask for assistance and 2 assist with a gait belt (1/10/23). 3.1-45(a)(1) 3.1-45(a)(2)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in			

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	the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or			

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	prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on observation, interview and record review the facility failed to have an indication for the use of an antipsychotic medication, failed to implement behavioral interventions, failed to monitor antipsychotic medication and failed to provide education of the risk of using an antipsychotic medication for 3 of 5 residents reviewed for unnecessary medication use (Resident 20, Resident 30 and Resident 4). Findings include: 1.) Review of the record of Resident 20 on 1/4/22 at 1:20 p.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease, altered mental status, cerebral infarction, history of falling, diabetes mellitus, hypertension, dementia,, osteoarthritis and anxiety. The CNA behavior communication form for Resident 20, dated 8/18/22, indicated the resident was being physically abusive to the staff and was hitting and kicking. There were no documented interventions attempted. The CNA behavior communication form for Resident 20, dated 8/30/22, indicated the resident was pulling the staff's hair. The interventions were talk/listen to the resident and reassured. These interventions were successful. The CNA behavior communication form for Resident 20, dated 8/30/22, indicated the resident was being physically abusive to staff and was scratching the staff's arm. The interventions were talk/listen to the resident and reassured. These interventions were successful.	F 0758	Residents that use psychotropic medications receive applicable behavior interventions, indication for use, monitoring and education related to risk. Surveyors were provided documentation of specific behaviors for resident 20. The provided documentation of behaviors reflective of potential for resident to cause harm to self or others even though non pharmacological interventions were effective at times. Her family was informed of medication being started at the timethe order was obtained and they were in agreement. Attending provider was interviewed and did identify that any underlying medical condition was ruled out as cause for behavior that was recurring frequently although interventions implemented. Resident family has received full education including “black box warning” for Seroquel use and informed consent was given for continued use. Monitoring /tracking are in place related to medication use. Resident 30 was seen by attending provider on 1-17-23 and clarified indication for use of Abilify as an adjunct treatment with her antidepressant after she saw	01/17/2023

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	The CNA behavior communication form for Resident 20, dated 8/31/22, indicated the resident was being physically abusive to staff and was hitting, biting, kicking and scratching. The interventions were talk/listen to the resident and reassured. These interventions were successful. The CNA behavior communication form for Resident 20, dated 9/1//22, indicated the resident was being physically abusive to staff and was hitting, biting, yelling and scratching. The interventions were talk/listen to the resident and reassured. These interventions were successful. The CNA behavior communication form for Resident 20, dated 9/3//22, indicated the resident was being physically abusive to staff and was hitting, pinching and kicking. The interventions were talk/listen to the resident and offered a quiet area. These interventions were unsuccessful. The CNA behavior communication form for Resident 20, dated 9/7//22, indicated the resident was being physically abusive to staff and was pinching and digging her nails in the staff's hand. The intervention was leave the resident alone. The CNA behavior communication form for Resident 20, dated 9/13//22, indicated the resident was being physically abusive to staff and was scratching and made the staff's hand bleed. The intervention was reassure the resident and it was successful. The CNA behavior communication form for Resident 20, dated 9/20//22, indicated the resident was being physically abusive to staff and was hitting and pinching staff. The interventions were talk/listen to the resident and reassured. These interventions were successful. There were no		resident in May 2022 and resident self-reported continued depression symptoms. Resident consented to treatment at time medication started and she has now signed informed consent for psychotropic medications including any “black box warnings”. Applicable monitoring/tracking are in place related to medication use. Resident 4 had had careplan and medication review on 1-17-23by attending provider. Provider reviewed and clarified indication for use. Appropriate monitoring and tracking are in place and services will continue. Family was informed and consented when medication started in September 2022 and consent continues after informed consent review with “black box warnings” provided. Residents receiving psychoactive medication records were reviewed to ensure applicable behavior interventions, monitoring and indications for use were in place. Informed consents specific to individual resident ordered medications including “black box warning” were reviewed and updates if necessary. Director of Nursing or designee will review Electronic Health Record (progress notes -all and orders), 24-hour report sheets and care assignments daily for behaviors,	

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	further CNA behavior communication forms documented. The nursing behavior note for Resident 20, dated 9/2/22, indicated the resident had a behavior of pinching and scratching staff. Intervention was 1:1 conversation and reassured. These interventions were successful. The nursing behavior note for Resident 20, dated 9/3/22, indicated the resident was scratching and punching staff when they tried to get her up in the morning. The staff attempted to take her to activities and the resident scratched the staff's arm and grabbing their shirt and kicking at staff. The staff talked with resident and listened to the resident and offered a quiet area. The resident remained unchanged. The nursing behavior note for Resident 20, dated 9/13/22, indicated the resident scratched staff hand while in the shower room. The intervention was resident left alone and reapproached. The nursing behavior note for Resident 20, dated 10/1/22 through 10/15/22 the resident had no documented behavior. The nursing behavior note for Resident 20, dated 10/16/22, indicated the resident was pinching scratching and spitting at staff. The intervention was 1:1 and talking. The behavior remained unchanged. The nursing behavior note for Resident 20, dated 10/19/22, indicated the resident was kicking and hitting staff. The intervention was reassured resident. The behavior remained unchanged. The nursing behavior note for Resident 20, dated		interventions and any related ordered medication if applicable x 8 weeks, then weekly for 4 months to ensure all required documentation is in place. Negative findings will be reported to facility QAPI committee. Compliance 1/17/23	

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	10/20/22 through 11/4/22, the resident had no behaviors. The nursing behavior note for Resident 20, dated 11/5/22, indicated the resident was kicking and hitting staff. The interventions were reassured the resident and talked with her and walked away. The intervention was successful. The nursing behavior note for Resident 20, dated 11/6/22 through 11/17/22, the resident had no documented behaviors. The nursing behavior note for Resident 20, dated 11/18/22, indicated the resident was yelling and crying very loudly in the hallway before dinner. Staff attempted to redirect the resident but this did not work. The resident went into the dining room and continued to yell at others and crying. The resident threw a small vase and broke it. Staff attempted to assist the resident with eating but was unsuccessful. The resident continued to yell at others and crying while making her way out of the dining room. The resident attempted to hit, grab and bite staff. The staff took the resident to her room and once in front of her bed the resident mostly stopped her behaviors. The stated she wanted to go to bed and staff assisted her to bed and covered her up. The resident cried for a couple more minutes, but then completely calmed down and went to sleep. The facility would review the resident's medications and complete a pain assessment, the resident does have dementia. The physician order for Resident 20, dated 11/22/22, indicated the resident was ordered seroquel (antipsychotic medication) 25 milligrams (mg) at night for dementia with behaviors. During an observation on 1/4/23 at 2:12 p.m.,			

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	Resident 20 was laying in bed with her eyes closed. During an observation on 1/5/23 at 1:46 p.m., Resident 20 was laying in bed with her eyes closed. During an interview with the Administrator on 1/5/23 at 2:01 p.m., the facility had not been monitoring for side effects of the seroquel for Resident 20, but they would be now. The resident had not seen psychiatric services. During an observation on 1/6/23 at 11:00 a.m., Resident 20 was laying in bed. CNA 1 asked the resident if she was ready to get up and the resident shook her head no and pointed to the door for staff to leave. CNA 2 was standing there and when queried if the facility attempted different care givers to see if the resident would get up, CNA 2 indicated yes they did. CNA 2 did not attempt to see if the resident would get up for him and no other interventions were attempted. During an observation on 1/9/23 at 2:16 p.m., Resident 20 was laying in bed with her eyes closed. During an interview with the Administrator on 1/10/23 at 10:14 a.m., indicated the facility had not provided Resident 20's family education on the risk of seroquel and the education would be mailed to them today. The Administrator provided a copy the education that would be mailed to the resident's family. During an interview with Resident 20's Nurse Practitioner (NP) on 1/10/23 at 10:36 a.m., indicated the rationale behind why the medication of an antipsychotic was being used to treat Resident			

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	20's dementia, the NP indicated the resident was combative with staff and the facility ruled out infection and started her on seroquel. When queried if the NP had been aware that the non pharmalogical interventions staff were using for Resident 20's behaviors were mostly successful, the NP indicated it was not reported to her that the non pharmalogical interventions had been successful for her behaviors. The informed consent for the medication seroquel for Resident 20's family dated 1/10/23, indicated "warning: [Black Box Warning] Increased mortality in elderly patents with dementia related psychosis: Elderly patients with dementia related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo." "Although the causes of death varied, most of the deaths appeared to be either cardiovascular (e.g. heart failure, sudden death) or infectious (e.g. pneumonia) in nature. "This drug is not approved for the treatment of patients with dementia-related psychosis." 2. Resident 30's record was reviewed on 1/5/23 at 12:59 p.m. The record indicated diagnoses that included, but were not limited to, repeated falls, altered mental status, high blood pressure, anxiety, depression, and vascular dementia. An Annual Minimum Data Set (MDS) assessment, dated 4/22/22, indicated Resident 30 was cognitively intact, speech was clear, had no moods or behaviors, did not receive antipsychotic medications. A Quarterly MDS assessment, dated 11/28/22, indicated Resident 30 was cognitively intact, speech was clear, had moods of feeling down, depressed or hopeless, trouble falling or staying asleep, or sleeping too much, feeling tired or			

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	having little energy, poor appetite or overeating, had no behaviors, received an antipsychotic routinely for seven out of seven days of the assessment, a gradual dose reduction had not been attempted, and a gradual dose reduction has not been documented by a physician as clinically contraindicated. A care plan, dated 6/1/22, indicated a problem of "Disruptive verbally. This res is rude to her peers; makes fun of them, laughs at them, tells them what to do, etc. Diagnosis of Mood Disorder...6/15/22 Manifested by: verbal outbursts, verbal intimidation. Approach: Nurses - provide calm environment, administer medications as ordered by physician; Abilify, redirect, do not reorient or argue with [Resident 30], if need be remove her from her peers if able. Nurse Aide - Positive approach with resident, count verbal outbursts, document and report behaviors to nurse and/or social services, maintain safety of resident and other residents, and other staff, if able remove [Resident 30] from the area...." Current physician's orders included an order for an antipsychotic medication - Abilify (generic name is aripiprazole) 2 milligrams by mouth every day, for mood disorder, with a start date of 5/5/22. On 1/10/23 at 10:45 a.m., the Nurse Practitioner said Resident 30 was on Abilify and she doesn't get a report of signs and symptoms but the Director of Nursing will call and let her know what is going on. She wasn't aware that mood disorder was not an accepted diagnosis for the use of an antipsychotic. An "Informed Consent for Medication" for the use of Abilify, indicated "Completion of this form is voluntary. If not completed, the medication			

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	cannot be administered without a court order unless in an emergency. This consent is maintained in the client's record and is accessible to authorized users...." The consent was signed by the resident on 1/10/23 and the Ability had been administered since 5/5/22. The informed consent included, but was not limited to, side effects and cautions such as changes in thinking, fever, muscle stiffness, low blood pressure when standing, fall risk, weight gain, and seizure. The following was indicated on the Informed Consent for Medication: "Warning: [Black Box Warning]: Increased Mortality in Elderly Patients with Dementia Related Psychosis: Elderly patients with dementia related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. Analyses of 17 placebo controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in the drug treated patients of between 1.6 to 1.7 times that seen in placebo treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug treated patients was about 4.5% compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature. Observational studies suggest that, similar to atypical antipsychotic drugs, treatment with conventional antipsychotic drugs may increase mortality. The extent to which the findings of increased mortality in observational studies may be attributed to the antipsychotic drug as opposed to some characteristic(s) of the patients is not clear. Aripiprazole is not approved for the treatment of patients with dementia-related psychosis."			

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	3. Resident 4's record was reviewed on 1/04/23 at 1:20 p.m. and indicated diagnoses that included, but were not limited to, cardiac arrhythmia, age-related physical debility, repeated falls, osteoporosis, hypertension, dementia with behavior disturbance, and heart failure. A Quarterly MDS, dated 8/26/22, indicated Resident 4 was severely impaired in cognitive skills for daily decision making, had no moods or behaviors, did not walk, and did not receive an antipsychotic medication. A Significant Change MDS, dated 10/12/22, indicated Resident 4 was severely impaired in cognitive skills for daily decision making, had a diagnosis of non-Alzheimer's dementia, did not walk, and received an antipsychotic medication. A care plan, dated 9/15/22, indicated a problem for "Potential for adverse medication side effects related to antipsychotic use manifested by: possible side effects: lethargy, loss of appetite, involuntary movements, tremors, chewing and /or tongue movements, muscle twitching, gait changes. Approach: Nurses - Monitor for side effects q (every) shift, notify physician of symptoms. Nurse Aide - report unusual behavior, report change in physical condition, report change in appetite. [Social Services] Involve family, make referrals, referred her to psych services, discuss in the monthly behavior management meeting. Goal: No adverse affects d/t (due to) med regimen, prevent and/or minimize the side effects of the psychotropic medications. Resident will receive the lowest possible dose necessary to control symptoms." On 1/05/23 at 9:46 a.m., Resident 4 was in bed, eyes closed.			

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	On 1/09/23 at 10:05 a.m., Resident 4 was in bed with her eyes closed. On 1/09/23 at 01:48 p.m., Resident 4 was up in her wheelchair in the activity room, sitting quietly with other residents, the activity aide was in the room. Current physician's orders included an order for the antipsychotic Seroquel 25 milligrams by mouth at bedtime for dementia, with a start date of 9/8/22. A Pharmacy review, dated 9/29/22, indicated: "[Resident 4] is receiving the antipsychotic agent Seroquel but lacks an allowable diagnosis to support its use. The following are considered appropriate diagnoses/conditions:...Dementing illnesses with associated behavioral symptoms." The physician selected "Agree" and chose Dementia with behavioral disturbance. Signed 9/29/22 by the Nurse Practitioner. During an interview, on 1/10/23 at 10:37 a.m., the Nurse Practitioner indicated they started Resident 4 on the Seroquel when she started to have behaviors with her dementia, they got psych involved, and she wasn't aware that a dementing illness with associated behavioral symptoms was not an accepted diagnosis for the use of an antipsychotic. A policy for "Psychoactive Medication Protocol" was provided by the Interim Executive Director on 1/6/23 at 1:22 p.m. The policy included, but was not limited to, "Purpose: To ensure appropriate procedures are followed and subsequent documentation is completed prior to the initiation or change of a psychoactive medication and to ensure ongoing targeted behavior tracking for comprehensive assessment and evaluation purposes. Protocol: 1. Psychoactive medications			

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(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
	include antipsychotics, antianxiety agents, sedatives/hypnotics, antidepressants and "other medications" as described below...2. The Interdisciplinary Team will identify target behaviors and develop a care plan to include treatment goals and evaluation of precipitating events, if any, in the resident's environment...3. Enter the appropriate target behaviors in the appropriate [treatment administration record] folder and begin documenting every shift. Make an appropriate corresponding entry in the medical record as warranted. 5. Physician order obtained MUST include an appropriate diagnosis for medication use and the desired therapeutic goal for the medication (i.e. reduction in the frequency or severity of a targeted behavior) for any psychoactive medications...." 3.1-48(a)(3) 3.1-48(b)(2)			
F 0790 SS=D Bldg. 00	483.55(a)(1)-(5) Routine/Emergency Dental Srvcs in SNFs §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services;			

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	01/10/2023

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	§483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.			
	Based on observation, interview and record review the facility failed to provide routine dental services for a resident who had poor fitting dentures for 1 of 2 residents reviewed for dental status (Resident 12). Findings include: During an observation on 1/3/23 at 11:31 a.m., Resident 12 was laying in bed, the resident had no teeth. During an observation on 1/4/23 at 2:13 p.m., Resident 12 was laying in bed, the resident had no teeth. During an observation and interview on 1/5/23 at	F 0790	Facility does assist residents in obtaining dental service with provider. Resident 12 was assisted by staff with oral hygiene and a updated BOHSE (Brief Oral Health Status Examination) was completed. Discussion was had with family as indicated would like consult for denture replacement as hers were more than 10 years old. Resident had no adverse effect related to allegation as evident by tolerating diet with no weight loss or oral pain/health issues.	01/26/2023

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	12:53 p.m., Resident 12 was laying in her bed with no teeth. Interview with Resident 12's family member indicated the resident did have dentures but she did not always wear them because they fall out. The family member indicated even when staff used denture adhesive they still fell out and it "aggravated" the resident so she did not wear her dentures often. The family member indicated she needed to see a dentist to see if they could be adjusted or replaced. The resident's family member was unsure how long the resident's dentures had not fit but it had been going on for awhile. Review of the record of Resident 12 on 1/10/23 at 1:38 p.m., dementia, hypertension, iron deficiency anemia, anxiety, age related debility and chronic pain syndrome. During an interview with the Administrator on 1/6/23 at 10:29 a.m., the facility could not find documentation that Resident 12 had ever seen a dentist. During an interview with the Administrator on 1/6/23 at 1:45 p.m., indicated residents at the facility did not receive routine dental visits and were only seen on a as needed basis. During an interview with the Administrator on 1/9/23 at 10:32 a.m., indicated the dental company the facility used stopped provided services in 2020. The facility is now going to contract with a different dental company. The new dental company had not started at the facility yet, but if a resident needs to be seen the facility would make arrangements with the local dentist. During an interview with the Administrator on 1/10/23 at 3:26 p.m., Resident 12 would be seen by a dentist on 1/13/23.		All other resident BOHSE were reviewed and resident or family discussions completed regarding routine services. MDS coordinator will audit all BOHSE with RAI process to ensure applicable referrals made as indicated as well as for routine services when wanted. Negative findings will be reported to facility QAPI committee. Compliance 1/26/23	

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	The dental services policy provided by the Administrator on 1/6/23 at 1:45 p.m., indicated the dental needs of residents shall be adequately cared for through proper hygiene and regular and emergency dental care. 3.1-24(a)(1)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: January 3, 4, 5, 6, 9 & 10, 2023 Facility number: 001126 Residential Census: 1 Flatrock River Lodge was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed on January 13, 2023	R 0000	Flatrock River Lodge respectfully requests desk review for the following alleged deficiencies. This plan of correction is to serve as Flatrock River Lodge's credible allegation of compliance on 1-27-23. Submission of this plan of correction does not constitute an admission by Flatrock River that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Neither does this submission constitute an agreement or admission of the survey allegations.	