

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN RD NEW ALBANY, IN 47150
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F000000	<p>This visit was for the Investigation of Complaint #IN00143026.</p> <p>Complaint #IN00143026-Substantiated. Federal/State deficiency related to the allegation are cited at F309.</p> <p>Survey dates: February 28 and March 4, 2014.</p> <p>Facility number: 001144 Provider number: 155668 AIM number: 200256980</p> <p>Survey team: Joan Laux, RN/TC Caitlin Lewis, RN</p> <p>Census bed type: SNF: 54 SNF/NF: 70 Residential: 4 Total: 128</p> <p>Census payor type: Medicare: 29 Medicaid: 40 Other: 59 Total: 128</p> <p>Sample: 4</p>	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2014	
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN RD NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
F000309 SS=E	<p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review the facility failed to ensure residents were receiving restorative care as planned. This deficient practice affected 24 out of 24 residents reviewed for restorative care.</p> <p>Findings include: During an interview with LPN # 3 on 2/28/2014 at 1:48p.m., she indicated the facility employs 2 restorative aides, who are also CNAs (Certified Nursing Assistants). The aides are employed for restorative care, but at times are asked to work the floor as CNAs. The restorative aides have a daily list of residents that need restorative care, and a list of tasks to</p>	F000309	This plan of correction constitutes Diversicare of Providence's credible allegation of compliance for the cited deficiency. Nothing in this plan of correction should be construed as admission by the facility of any violation of state and federal statues, regulations or standards of care. This plan of correction is to demonstrate compliance of the state and federal requirements cited during a complaint survey. 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Unable to go back and correct for the 24 out of 24 residents reviewed for restorative care. No declines occurred with any of the 24 residents. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No other	04/03/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2014	
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN RD NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>be completed for these residents. They are also responsible for restorative dining. The LPN (Licensed Practical Nurse) indicated the restorative aides are pulled to work as CNAs on the floor "a lot." She indicated this could affect the residents, because sometimes restorative work cannot be completed due to lack of staffing. The restorative aides have been pulled "about 17 days out of the month." Around 8 CNAs have quit within the last month. More CNAs are being hired to cover the floor. These CNAs are not out of training, so it has not affected the staffing so far. "We are not able to hire any RNAs (Restorative Nursing Aides)." During an interview with CNA #5 on 2/28/2014 at 1:50p.m., she indicated restorative aides are pulled to to cover the floor as CNAs frequently. During an interview with LPN # 1 on 2/28/2014 at 2:00 p.m., she indicated restorative aides are not on the planned schedule to work the floor. However, when there are unplanned call-ins without any notice then the restorative aides are</p>		<p>residents have the potential to be affected due to restorative plans were only on 24 residents. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: All residents on restorative care will be reviewed and placed on a Functional Maintenance plan to be carried by the CNA floor staff if appropriate. CNA floor staff will be re-educated by therapy staff on passive/active range of motion and other treatment modalities. Staffing patterns will be re-evaluated and adjusted as needed to accommodate FMP programming. The DON/Designee will oversee the program and the functional maintenance plans received by therapy. Therapy will educate the floor staff responsible for the plan with each new plan as appropriate. The facility will monitor with input from staff of any changes in level of function and refer back to therapy as needed. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The DON/designee will monitor for completion of the FMP plans daily for one month then weekly for the remainder of the year. The DON/Designee will address any concerns. Findings will be reported to the QI committee.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN RD NEW ALBANY, IN 47150
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

	<p>used to work as CNAs on the floor. They alternate between the scheduling person, who is a CNA and the restorative aides when there are last minute call-ins. This is an issue during first shift, because there is never a notice given before a call-in and there is no time to get anyone in the building. There have been a lot of call-ins within the last few months. There have been about 10 days out of the last month that restorative aides have been pulled from their job to work as CNAs on the floor. The facility tries to get PRN (as needed) and agency staff to cover before we pull the restorative aides. There are not a lot of agency employees for day shift. First shift is always the hardest to fill.</p> <p>During an interview with LPN #3 on 3/4/2014 at 8:55 a.m., she indicated on the restorative care log there would be blank spaces or circles if the resident did not receive scheduled restorative care that day. LPN #3 proceeded to highlight all days on these restorative logs when care was missed.</p> <p>During an interview with CNA #1 on</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN RD NEW ALBANY, IN 47150
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>3/4/2014 at 9:15 a.m., she indicated the facility does not have enough staff. "I don't think it's fair to the residents." Restorative aides are being pulled "almost daily" to work as CNAs on the floor. "They're never left to do their job. They' re always pulled."</p> <p>During an interview with CNA #2 on 3/4/2014 at 9:30 a.m., she indicated there is not enough staff for restorative care to be completed. "They're (restorative aides) pulled off the hall and there's only one. When they need a CNA on the hall they'll pull from restorative."</p> <p>During an interview with CNA #3 on 3/4/2014 at 9:33 a.m., she indicated there are not enough CNA's on staff. They cannot get restorative care completed.</p> <p>During an interview with the DON on 3/4/2014 at 9:38 a.m., she indicated the facility does not have a policy and procedure on restorative care.</p> <p>During record review on 2/28/2014 at 10:40 a.m., the "Resident Council Minutes" dated 12/9/2013 indicated, "Restorative or CNAs do not have time to walk them[Residents]. They</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN RD NEW ALBANY, IN 47150
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>feel the restorative is working as CNAs a lot."</p> <p>During record review on 2/28/2014 at 11:00 a.m., the "Daily Nursing Schedules" for the month of February 2014 indicated 4 days out of 28 days in February restorative aides were scheduled to come in as restorative aides, but were pulled to the floor to work as CNAs for the day. 15 days out of 28 days in February restorative aides were scheduled to work as floor CNAs.</p> <p>During record review on 3/4/2014 at 8:40 a.m., a "Position Description" for "Rehabilitation Nursing Assistant Restorative Nursing Assistant" indicated the "Accountability Objective: Responsible to work with residents needing restorative nursing measures to provide skill practice in such activities as walking, mobility, dressing and grooming, eating and swallowing, transferring, ambulation care, and communication in order to improve and maintain function in physical abilities and ADL's, and prevent further impairment..." The "Key Responsibilities" indicated,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN RD NEW ALBANY, IN 47150
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>"administer restorative activities specific to resident needs based on the plan of care, perform transfers, bed mobility, positioning, and range of motion (passive/active), perform general strengthening exercises, ensure placement of restorative devices/equipment, assist with turning and positioning of residents as needed, document per treatment activity, report changes in resident condition, evidence of pain or motivational level to licensed nurse, notify restorative nurse, charge nurse or appropriate therapy discipline of problems, referrals, and reassessment needs, follow appropriate safety, hygiene and infection control measures, maintain consistent resident care scheduled and be efficient in use of time and attend all meetings and in-services required."</p> <p>During record review on 3/4/2014 at 9:50 a.m., restorative care logs dated February 2014 were reviewed for 24 out of 24 residents receiving restorative care. Out of the 24 residents reviewed restorative care was not received as scheduled 267</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN RD NEW ALBANY, IN 47150
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	times throughout the month of February 2014. 3.1-37(a) This federal tag relates to complaint #IN00143016			