

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 05/15/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE	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
F 000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00172945.</p> <p>Complaint IN00172945 - Substantiated. Federal/State deficiencies related to the allegations are cited at F-157, F-280, F-327, and F-329.</p> <p>Survey dates: May 14 and 15, 2015.</p> <p>Facility number: 001144 Provider number: 155668 AIM number: 200256980</p> <p>Census bed type: SNF: 65 SNF/NF: 67 Residential: 3 Total: 135</p> <p>Census payor type: Medicare: 27 Medicaid: 56 Other: 49 Total: 132</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	<p>This plan of correction constitutes Diversicare of Providence's credible allegation of compliance for the cited deficiencies. Nothing in this plan of correction should be construed as admission by the facility of any violation of state and federal statutes, regulations or standards of care. This plan of correction is to demonstrate compliance of the state and federal requirements cited during a compliant survey.</p> <p>IDR request: Diversicare of Providence is requesting that F329 be deleted from the survey findings. Resident #8 had a diagnosis of Chronic Kidney Disease and CHF. The resident's norm was to have fluctuations in her edema and weight. This was normal and expected for resident #8. Resident # 8 was seen by the following and meds reviewed as well on these dates:</p> <p>1/16 Renal Team 1/23 Primary MD 1/26 Renal Team 1/29 Drug Review by Pharmacy Consultant 2/6 Primary MD 2/9 Renal Team 2/18 Drug Review by Pharmacy Consultant 2/23 Renal Team 3/4 Renal Team</p> <p>Resident #8 was scheduled to see a member of the Renal Team again on 3/9 but discharged on</p>	

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 05/15/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE			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	
F 157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as</p>		3/8 Resident #8 was also scheduled to have labs drawn again on 3/9 Routine labs were drawn and monitored by the physicians Resident #8 medication regimen was being handled by their Health Care Provider who reviewed the medications several times during this time period, therefore F329 should not have been cited		

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 05/15/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE	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>specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify the physician of a resident's significant weight change for 1 of 3 residents reviewed for weight loss. (Resident #B)</p> <p>Findings include:</p> <p>The closed clinical record for Resident #B was reviewed on 5/15/15 at 9:00 a.m. and indicated the following:</p> <p>Diagnoses for Resident #B included, but were not limited to, congestive heart failure and dementia.</p> <p>The MDS (Minimum Data Set) assessment, dated 2/27/15, indicated Resident #B required the physical assistance of one staff person with eating and drinking.</p> <p>Review of Resident #B's weight record for January, 2015 through March, 2015, indicated the following weights:</p> <p>1/25/15 - 120.3 pounds 2/01/15 - 133 pounds 2/06/15 - 126 pounds</p>	F 157	<p>1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Unable to correct for resident #8 due to resident is no longer at facility 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; All resident weights will be reviewed and the physician and responsible party will be notified by ADON's/Designee if any significant weight changes are identified. 3) What measure will be put into place or what systemic changes will be made to ensure that the deficient does not recur; Nursing staff will be in-serviced on notification of significant weight changes All monthly and weekly weights will be reviewed by the (2) Assistant Director of Nursing and Director of Nursing. The physician and responsible party will be notified of any significant weight changes and this notification will be noted in the nursing notes</p> <p>Director of Nursing/Designee will audit notification of significant weight changes monthly for three months and then quarterly</p>	06/14/2015

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 05/15/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE	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>2/13/15 - 116 pounds 2/20/15 - 107.6 pounds 3/01/15 - 102.9 pounds</p> <p>During an interview with the Director of Nursing on 5/15/15 at 9:15 a.m., she indicated physicians were notified, per facility policy, when residents have significant weight changes. A current copy of the Policy and Procedure titled, "Notification of Changes", was provided by the DON during this interview. The document included, but was not limited to, the following: "...Purpose: To ensure that a resident and their legal representative or family member are informed of changes in their medical condition and/or treatment...Procedure: 1. Licensed Nurse will notify the Attending Physician or designated physician extender, i.e. NP/PA when a change in health status occurs...3. Licensed Nurse will notify resident's legal representative or family member...4. Documentation of changes and who was notified, time and date of notification, shall be entered into the Nurses Notes...".</p> <p>During an interview on 5/15/15, at 1:10 p.m., RN (Registered Nurse) #9 indicated 5 pounds weight loss in one week would be a significant weight loss and the resident's physician should be notified.</p>		<p>thereafter 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; Director of Nursing/Designee will monitor notification of significant weight changes monthly for three months and then quarterly thereafter 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 05/15/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE	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
F 280 SS=D Bldg. 00	<p>During an interview on 5/15/15, at 1:20 p.m., LPN (Licensed Practical Nurse) #8 indicated a significant weight loss in one week would be 2 pounds or more and she would notify the MD (medical doctor) of this weight change.</p> <p>The clinical record for Resident #B lacked documentation of notification, to the resident's physician and responsible party, of the significant weight changes.</p> <p>This Federal tag relates to Complaint IN00172945.</p> <p>3.1-5(a)(2)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</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 05/15/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE	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>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to ensure a comprehensive care plan was in place for monitoring a resident at risk for dehydration due to use of multiple diuretics for 1 of 3 resident's reviewed for care plans. (Resident #B)</p> <p>Findings include:</p> <p>The closed clinical record for Resident #B was reviewed on 5/15/15 at 9:00 a.m. Diagnoses included, but were not limited to, congestive heart failure and dementia.</p> <p>Review of the February, 2015 and March, 2015 Medication Administration Record (MAR), indicated Resident #B was receiving the following diuretics (medication used to reduce fluid):</p> <p>Zaroxolyn, 2.5 mg (milligrams) on Monday, Wednesday and Friday.</p>	F 280	<p>1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Unable to correct for resident #8 due to resident is no longer at the facility 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; All residents receiving diuretics will be reviewed to assure an appropriate care plan is in place Verifying a care plan is in place for residents receiving diuretics will be added to the admission checklist 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Licensed staff and MDS staff will be in-serviced on verifying and implementing a diuretic care plan is in place for those residents receiving diuretics Director of Nursing/Designee will audit during routine morning clinical meeting</p>	06/14/2015

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 05/15/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE			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	
F 327 SS=G Bldg. 00	<p>Spironolactone, 25 mg once a day at 8 a.m. Lasix, 20 mg every morning and 10 mg every afternoon at 4 p.m.</p> <p>The clinical record for Resident #B lacked a care plan for the monitoring of adverse effects while taking three different diuretics.</p> <p>During an interview with the Director of Nursing on 5/15/25 at 1:28 p.m., she indicated Resident #B did not have a care plan for diuretic use.</p> <p>This Federal tag relates to Complaint IN00172945.</p> <p>3.1-35(a) 3.1-35(b)(1)</p> <p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Based on interview and record review,</p>	F 327	<p>orders for new diuretic orders, changes in diuretic order and new admits with diuretic orders to verify care plan is in place and/or updated as needed 4) Director of Nursing/Designee will conduct monthly audits of 20% of residents receiving diuretics for appropriate care plans in place The findings will be reported to the QI committee</p> <p>1) What corrective action(s) will</p>	06/14/2015	

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 05/15/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE			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>the facility failed to maintain proper hydration for a dependent resident, requiring assistance with fluid intake, resulting in the resident becoming dehydrated and requiring hospitalization for 1 of 3 residents reviewed for hydration. (Resident #B)</p> <p>Findings include:</p> <p>The closed clinical record for Resident #B was reviewed on 5/15/15 at 9:00 a.m. and indicated the following:</p> <p>Diagnoses for Resident #B included, but were not limited to, congestive heart failure and dementia.</p> <p>The current MDS (Minimum Data Set) assessment, dated 2/27/15, indicated Resident #B required the physical assistance of one staff person for eating and drinking.</p> <p>Registered Dietician Evaluation, dated 9/02/14, indicated the daily fluid/water requirement for Resident #B was 1325 ml (milliliters) per day.</p> <p>Weekly nursing note, dated 1/05/15, indicated Resident #B's skin was warm, dry and intact with no edema (swelling) noted.</p>		<p>be accomplished for those residents found to have been affected by the deficient practice; Unable to correct for resident #8 due to resident is no longer at the facility 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; All residents receiving diuretics will be evaluated for hydration 3) What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not recur; Licensed staff will be in-serviced on signs and symptoms of dehydration; diuretics and their side effects A weekly hydration evaluation form will be implemented that monitors signs of dehydration The evaluation form will be reviewed weekly by the IDT team Pharmacy to send a weekly report to DON of those residents on diuretics to be reviewed with the hydration evaluation form Fluid intakes will be completed for those residents with specific MD orders to complete Residents will receive weekly skins assessments on all residents and any signs/symptoms of dehydration will be noted in nurse's note and physician/family notified 4) Director of Nursing/Designee will audit the weekly hydration evaluation form for the residents on diuretics weekly for one month</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 05/15/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE	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>Weekly nursing note, dated 1/12/15, indicated resident had slight swelling in bilateral (both) lower extremities. The swelling was described as non-pitting (skin did not stay indented if pushed in).</p> <p>Weekly nursing note, dated 1/26/15, indicated, "3+ pitting (skin remained indented deeply, when pushed in) edema to bilateral lower extremities. Lasix (medication to reduce fluid/swelling) started today."</p> <p>Physician's orders for Resident #B indicated new orders were written on 12/15/14 for the diuretic (medication to reduce fluid/swelling), Lasix 20 mg (milligrams) to be administered once daily. This order was discontinued on 01/06/15.</p> <p>Physician's orders for Resident #B indicated new orders were written on 1/23/15 for the diuretic, Spironolactone 25 mg to be administered once daily. This order was discontinued on 3/11/15.</p> <p>Physician's orders for Resident #B indicated new orders were written on 1/26/15 for the diuretic, Lasix 10 mg to be administered once daily. On 2/02/15, this medication was increased to Lasix 20 mg, once daily in the morning and Lasix 10 mg in the afternoon at 4:00 p.m. This</p>		and then monthly thereafter. DNS/Designee will also audit 10% of skin assessment sheets weekly for one month, monthly for three months and then quarterly thereafter. Findings will be reported to the QI committee.	

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 05/15/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE	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>order was discontinued 3/11/15.</p> <p>Physician's orders for Resident #B indicated new orders were written on 2/09/15 for the diuretic Zaroxolyn 2.5 mg, to be administered every Monday, Wednesday and Friday.</p> <p>The clinical record for Resident #B indicated the resident was on 3 different diuretics to remove excess fluid due to swelling from 2/9/15 through 3/8/15, when the resident was discharged from the facility due to hospitalization.</p> <p>The weekly nursing note for Resident #B, dated 2/23/15, indicated "swelling has went down."</p> <p>The weekly nursing note for Resident #B, dated 3/02/15, had the "No" box checked for edema, in the skin section of the assessment, indicating the resident did not have any swelling.</p> <p>The Physician's Progress Notes, dated 3/4/15, indicated Resident #B had no edema.</p> <p>The clinical record for Resident #B did not contain any indication of an attempt to reduce the resident's diuretic use in response to the noted absence of edema by the nursing staff.</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 05/15/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE	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>The clinical record for Resident #B did not contain any documentation regarding monitoring of daily fluid intake and output.</p> <p>The laboratory record for Resident #B indicated labs were monitored for diuretic use and hydration status. Labs reported as follows:</p> <p>1/5/15 - Results were: Sodium 140, Potassium 4.9, Chloride 102, BUN 46, Creatinine 1.0, Calcium 10.5, GFR 52.</p> <p>Normal values for these labs included: Sodium 135-145, Potassium 3.5-5.3, Chloride 96-110, BUN 7-25, Creatinine 0.6-1.3, Calcium 8.4-10.2, GFR greater than 60.</p> <p>1/26/15 - Results were: Sodium 140, Potassium 4.7, Chloride 107, BUN 21, Creatinine 0.9, Calcium 10.0, GFR 59.</p> <p>2/5/15 - Results were: Sodium 138, Potassium 4.4, Chloride 101, BUN 24, Creatinine 1.0, Calcium 10.3, GFR 52.</p> <p>2/6/15 - Results were: Sodium (not tested), Potassium 4.6, Chloride (not tested), BUN 25, Creatinine 1.0, Calcium (not tested), GFR 52.</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 05/15/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE	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>2/16/15 - Results were: Sodium 138, Potassium 4.5, Chloride 94, BUN 26, Creatinine 1.1, Calcium 10.6, GFR 46.</p> <p>The clinical record for Resident #B did not contain any further labs to monitor hydration status related to diuretic use between 2/16/15 and 3/06/15.</p> <p>A lab dated 3/06/15 indicated Resident #B had a magnesium level of 2.9 (normal values were 1.5-2.5). This lab test was ordered by the physician on 3/06/15 as a response to a recommendation from the consulting Pharmacist on 2/18/15 who noted the resident was on a magnesium supplement and did not have a current lab to monitor the serum (blood) magnesium level.</p> <p>During an interview on 5/14/15 at 8:10 p.m., Resident #B's POA (Power of Attorney), indicated the family had concerns about the care of the resident. The POA indicated the resident had been showing signs of dehydration for at least 3 weeks prior to being sent to the hospital on 3/8/15. The POA indicated the resident had a dry mouth, raspy voice, eyes were sunken in, and temples were sunken in. The POA also indicated the resident showed in increase in confusion and had significant weight loss related to the use of the diuretics. The POA also</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 05/15/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE	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>indicated the family had voiced their concerns to the facility staff and there were no changes in the resident's care.</p> <p>The clinical record for Resident #B lacked interventions and physician notification regarding the family concerns.</p> <p>Review of the "Nurses Notes" documented in the clinical record for Resident #B, included the following:</p> <p>3/8/15 12:25 p.m. "At approximately 1130AM [sic] CNA (Certified Nursing Assistant) notified this nurse that resident had a brief episode of being non responsive, BP (blood pressure) 92/58, Pulse 116, O2 Sat (oxygen saturation) 95% on room air, resident is noted to [sic] lethargic, call placed to MD (medical doctor), Daughter requested that MD call her personally to discuss treatment and medications."</p> <p>3/8/15 10:37 p.m. "At 1:00 pm resident transferred via [name of ambulance company] to [name of hospital] ER due to non-responsive episode per daughter request, report call to ER nurse."</p> <p>3/8/15 10:39 p.m. "Resident admitted to [name of hospital] due to dehydration, UTI [urinary tract infection], and renal</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 05/15/2015	
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE				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>(kidney) insufficiency."</p> <p>Review of the hospital document titled, "[name of hospital] ED Evaluation" dated 3/8/15, included, but was not limited to, the following: "Medical Decision...Comments: Patient is severely dehydrated...She will be admitted for further hydration therapy and evaluation..."</p> <p>Review of the hospital document titled, "[name of hospital] Renal Progress Note", dated 3/14/15, included, but was not limited to, the following: "Assessment/Plan: CKD III (Chronic Kidney Disease, stage 3) - from overdiuresis (excess release of water from the body by urination) ...hypokalemia... and ...dehydration..."</p> <p>Review of the hospital document titled, "[name of hospital] Hospitalist History and Physical", dated 3/08/15, indicated the following laboratory results for Resident #B:</p> <p>Sodium 137 (normal value 136-144) Potassium 3.4 (normal value 3.6-5.1) Chloride 87 (normal value 101-111) Carbon Dioxide 37 (normal value 22-32)</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 05/15/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE	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>BUN 116 (normal value 8-20) Creatinine 2.6 (normal value 0.4-1.0) Calcium 10.8 (normal value 8.9-10.3)</p> <p>These labs were drawn on 3/08/15 at 2:37 p.m. in the hospital emergency department.</p> <p>During an interview on 5/14/15 at 2:56 p.m., the Director of Nursing (DON) indicated the staff do not know how much a resident drinks because they "do not keep track".</p> <p>During an interview on 5/15/15 at 9:05 a.m., the Facility Administrator indicated the facility did not have a policy and procedure for intake of fluids less than dietary recommendations.</p> <p>During an interview on 5/15/15 at 2:30 p.m., the DON indicated the facility did not have a policy and procedure for the monitoring of fluid intake and output.</p> <p>This Federal tag relates to Complaint IN00172945.</p> <p>3.1-46(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/15/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE	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
--------------------	--	---------------	---	----------------------

F 329 SS=G Bldg. 00	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review,</p>	F 329	1) What corrective action(s) will	06/14/2015
---------------------------	---	-------	-----------------------------------	------------

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 05/15/2015	
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE				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>the facility failed to provide ongoing monitoring and evaluation of diuretic medications to prevent adverse consequences resulting in hospitalization for 1 of 3 residents reviewed for unnecessary medications. (Resident #B)</p> <p>Findings include:</p> <p>The closed clinical record for Resident #B was reviewed on 5/15/15 at 9:00 a.m. Diagnoses included, but were not limited to, congestive heart failure and dementia. The clinical record also indicated the following:</p> <p>The current MDS (Minimum Data Set) assessment, dated 2/27/15, indicated Resident #B required the physical assistance of one staff person for eating and drinking.</p> <p>The February, 2015 and March, 2015 Medication Administration Records, indicated Resident #B was receiving the following diuretics (medications to reduce fluid/swelling):</p> <p>Spironolactone, 25 mg (milligrams) daily. This medication was ordered by the physician on 1/23/15.</p> <p>Lasix, 20 mg every morning and 10 mg every afternoon. This medication was</p>		<p>be accomplished for those residents found to have been affected by the deficient practice; Unable to correct for resident #8 due to resident is no longer at the facility 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; Pharmacist will review residents receiving diuretics to assess their current diuretic regimen 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The Interdisciplinary Team will be in-serviced on reviewing diuretics weekly for appropriate regimen Licensed nursing staff will be in-serviced on notifying physician when resident is receiving diuretics but showing no signs of edema and documenting the physician notification The IDT Team will review residents on diuretics weekly and assess residents need to continue on current diuretic regimen A list of residents on diuretics will be given to the Medical Doctor or Nurse Practitioner weekly along with the IDT team notes related to resident assessment of their diuretic use Pharmacy Consultant to conduct monthly reviews of resident's medications 4) The Director of Nursing/Designee will audit resident's receiving diuretics</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 05/15/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE			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>ordered by the physician on 2/02/15 as in increase to the previous Lasix order (10 mg once daily-ordered 1/26/15).</p> <p>Zaroxolyn, 2.5 mg on Monday, Wednesday and Friday. This medication was ordered by the physician on 2/09/15.</p> <p>The clinical record for Resident #B indicated the resident was on 3 different diuretics to remove excess fluid due to swelling from 2/9/15 through 3/8/15, when the resident was discharged from the facility due to hospitalization.</p> <p>The weekly nursing note for Resident #B, dated 2/23/15, indicated "swelling has went down."</p> <p>The weekly nursing note for Resident #B, dated 3/02/15, had the "No" box checked for edema, in the skin section of the assessment, indicating the resident did not have any swelling.</p> <p>The Physician's Progress Notes, dated 3/4/15, indicated Resident #B had no edema.</p> <p>The clinical record for Resident #B did not contain any indication of an attempt to reduce the resident's diuretic use in response to the noted absence of edema by the nursing staff.</p>		monthly for three months then quarterly thereafter for appropriate regimen. These findings will be reported to the QI committee.		

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 05/15/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE	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>Resident #B's clinical record contained labs to monitor diuretic use and hydration status for the following dates:</p> <p>1/5/15 - Results were: Sodium 140, Potassium 4.9, Chloride 102, BUN 46, Creatinine 1.0, Calcium 10.5, GFR 52.</p> <p>1/26/15 - Results were: Sodium 140, Potassium 4.7, Chloride 107, BUN 21, Creatinine 0.9, Calcium 10.0, GFR 59.</p> <p>2/5/15 - Results were: Sodium 138, Potassium 4.4, Chloride 101, BUN 24, Creatinine 1.0, Calcium 10.3, GFR 52.</p> <p>2/6/15 - Results were: Sodium (not tested), Potassium 4.6, Chloride (not tested), BUN 25, Creatinine 1.0, Calcium (not tested), GFR 52.</p> <p>2/16/15 - Results were: Sodium 138, Potassium 4.5, Chloride 94, BUN 26, Creatinine 1.1, Calcium 10.6, GFR 46.</p> <p>Normal values for these labs included: Sodium 135-145, Potassium 3.5-5.3, Chloride 96-110, BUN 7-25, Creatinine 0.6-1.3, Calcium 8.4-10.2, GFR greater than 60.</p> <p>The clinical record for Resident #B did not contain any further labs to monitor</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 05/15/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE	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>possible fluid imbalance, related to diuretic use, after 2/16/15.</p> <p>One further lab was noted in Resident #B's clinical record, a lab dated 3/06/15 for a magnesium level. The lab was ordered by the physician on 3/06/15 as a response to a recommendation from the consulting Pharmacist on 2/18/15 who noted the resident was on a magnesium supplement and did not have a current lab to monitor the serum (blood) magnesium level. This lab result was: Magnesium 2.9 (normal values were 1.5-2.5).</p> <p>Resident #B's clinical record did not contain any pharmacy consults related to diuretic medications.</p> <p>The document titled "Care Plan Conference Summary", dated 3/5/15, included, but was not limited to, the following: "Plan of Care reviewed with (c with line over it) family via tele-conference. Discussed [resident name] medications and concerns regarding fluid intake and Lasix".</p> <p>The clinical record for Resident #B lacked documentation of interventions and physician notification related to the family concerns until 2 days after the care plan conference, on 3/7/15 at 8:36 p.m.</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 05/15/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE	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>A nursing note, documented on 3/7/15 at 8:36 p.m. indicated, "POA [Power of Attorney] voiced concerns regarding amount of diuretics resident is receiving [sic]. POA states she does not want resident receiving Zaroxolyn or 4pm Lasix dosage anymore. Notified [physician's name] and per family request medications D/C'd (discontinued). Will continue to monitor."</p> <p>The clinical record of Resident #B indicated the resident was discharged from the facility on 3/8/15 and admitted to the hospital for evaluation and treatment.</p> <p>A nursing note, documented on 3/8/15 at 12:25 p.m., indicated, "At approximately 1130AM [sic] CNA (Certified Nursing Assistant) notified this nurse that resident had a brief episode of being non responsive, BP (blood pressure) 92/58, Pulse 116, O2 Sat (oxygen saturation) 95% on room air, resident is noted to [sic] lethargic, call placed to MD (medical doctor), Daughter requested that MD call her personally to discuss treatment and medications."</p> <p>A nursing note, documented on 3/8/15 at 10:37 p.m., indicated, "At 1:00pm resident transferred via [name of ambulance company] to [name of</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 05/15/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE	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>hospital] ER due to non-responsive episode per daughter request, report call to ER nurse.</p> <p>A nursing note, documented on 3/8/15 at 10:39 p.m., indicated, "Resident admitted to [name of hospital] due to dehydration, UTI [urinary tract infection], and renal (kidney) insufficiency.</p> <p>Review of the hospital document titled "[name of hospital] Renal Progress Note", dated 3/14/15, included, but was not limited to the following: "...Assessment/Plan:...CKD III (Chronic Kidney Disease, stage 3) - From overdiuresis (excess release of water from the body by urination)...dehydration... and ...hypokalemia...".</p> <p>During an interview on 5/15/15 at 9:05 a.m., the Facility Administrator indicated the facility did not have a policy and procedure for the monitoring of residents on diuretics.</p> <p>This Federal tag relates to Complaint IN00172945.</p> <p>3.1-48(a)(6)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/15/2015
---	--	---	--

NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE	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