

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155668 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>04/30/2014 |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>DIVERSICARE OF PROVIDENCE LLC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4915 CHARLESTOWN RD<br>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 Recertification and State Licensure Survey. This visit included a State Licensure Survey. This visit also included the Investigation of Complaint IN00147522 and Complaint IN00145588.</p> <p>Complaint IN00147522-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00145588-Substantiated. No deficiencies restated to the allegations are cited.</p> <p>Survey Dates: April 21, 22, 23, 24, 25, 28, 29, &amp; 30, 2014</p> <p>Facility number: 001144<br/>Provider number: 155668<br/>AIM number: 200256980</p> <p>Survey team:<br/>Gwen Pumphrey RN,TC<br/>Gloria Reisert, MSW<br/>Chris Greeney, QIDP (4/21, 4/22, 4/23, 4/24, 4/25, 2014)</p> <p>Census bed type:<br/>SNF: 45</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:<br><br>155668 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                         |  | X3) DATE SURVEY COMPLETED<br><br>04/30/2014 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>DIVERSICARE OF PROVIDENCE LLC |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4915 CHARLESTOWN RD<br>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   |  |   |  |
| F000155<br>SS=D   | <p>SNF/NF: 65<br/>Residential: 4<br/>Total: 114</p> <p>Census payor type:<br/>Medicare: 25<br/>Medicaid: 48<br/>Other: 41<br/>Total: 114</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on May 8, 2014, by Brenda Meredith, R.N.</p> <p>483.10(b)(4)<br/>RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES<br/>The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining</p> |   |   |  |  |   |  |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155668 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>04/30/2014 |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>DIVERSICARE OF PROVIDENCE LLC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4915 CHARLESTOWN RD<br>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>written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. Based on record review and interviews, the facility failed to allow the resident the right to refuse his NPO (nothing by mouth) status. This deficient practice affected 1 of 2 residents reviewed for Resident Rights. (Resident #139)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #139 on 4/28/14 at 11:00 a.m. indicated the resident was admitted to the facility on 12/2/13 and had diagnoses which included, but were not limited to: malignant neoplasm esophagus and gastroesophageal reflux disorder.</p> <p>Nursing notes between 12/16/13 and 4/29/14 indicated the following entries:<br/>- "12/16/13 2:35 p.m. - Spoke with clinical manager at [name of hospice] regarding patient eating by mouth. She is going to contact MD [physician] and his [name of hospice] nurse to notify that patient had eaten food and have them follow up with NSG [nursing] and if MD</p> | F000155       | <p>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 previous actions that occurred with resident # 139. 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? Facility will complete a 100% audit on residents who have an NPO status to verify that facility is allowing their right to refuse their NPO status if they choose to do so. 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 staff will be in-serviced on residents right to refuse. Director of Nursing or Designee will audit 100% of residents with a NPO diet to verify their right to refuse is being honored weekly for one month, monthly for three months and then quarterly for the remainder of the year. 4) How the corrective action(s) will be monitored to ensure the deficient</p> | 05/28/2014           |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                  |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155668 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                         |  | X3) DATE SURVEY COMPLETED<br><br>04/30/2014 |  |
|---|---|---|--|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>DIVERSICARE OF PROVIDENCE LLC |   |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4915 CHARLESTOWN RD<br>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>wants to do anything different...Candy has been removed from patient's room."</p> <p>- "12/23/14 2:02 p.m. - resident was expressing anger and cursing at this nurse to not being able to eat. Resident stated he was angry at his doctor because he wanted to eat. This nurse redirected cursing and explained the reason and results of non compliance to doctors order...."</p> <p>- "12/24/13 12:30 p.m. - Resident came to med cart this morning requesting feeding. Noted to be chewing on something like a cracker, when resident asked to have feeding, some of the crumbs in resident's mouth were spat out...."</p> <p>- "12/29/13 1:43 p.m. - Spoke with resident this morning about NPO status. 'asked resident if he had been eating and drinking anything? Resident verbalized "NO, the doctor told me that if I did it would go straight to my lungs' ...Resident then stated 'Well, that's not entirely true. I have been sneaking cookies and eating them...."</p> <p>- "1/9/14 3:32 p.m. - On 1/8/14, this writer heard wander alarm and witnessed resident at vending machine outside of his wanderguard area purchasing food</p> |   | <p>practice will not recur, i.e., what quality assurance program will be put into place. Director of Nursing or designee will audit 100% of residents with a NPO diet to verify their right to refuse is being honored weekly for one month, monthly for three months and then quarterly for the remainder of the year. Findings will be reported to the QA committee.</p> |  |  |   |  |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155668 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>04/30/2014 |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>DIVERSICARE OF PROVIDENCE LLC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4915 CHARLESTOWN RD<br>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>items and overheard resident stating to NSG that he knows he is not supposed to have it (candy bar) but he is going to eat it anyway."</p> <p>- "1/27/14 - 3:55 p.m. - Daycare staff reports to this nurse resident noted getting candy out of candy machine. Resident reminded he is supposed to be NPO. Resident not noted to have candy at this time."</p> <p>- "3/17/14 10:30 a.m. - [Name of hospice] RN routine vs [visit]. Speech therapist in to speak with patient regarding risks of eating/drinking orally d/t [due to] cancer. Pt [patient]is ambulatory and wanders to the vending machine. Staff take away drinks when see...."</p> <p>During an interview with RN #1 on 4/28/14 at 3:30 p.m., she indicated that since the resident moved from 700 hall to 900 hall, it was not as big a problem with the resident getting to foods and drinks when he wasn't supposed to. "We would caution him on the risks and remove the food item if he let us."</p> <p>During an interview with RN #2 on 4/29/14 at 10:00 a.m., she indicated that the resident was found this morning with a cup of coffee and that when she asked</p> |               |   |                      |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155668 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>04/30/2014 |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>DIVERSICARE OF PROVIDENCE LLC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4915 CHARLESTOWN RD<br>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>him about it, he acknowledged he went and got a cup and was drinking it. The resident indicated to her "I got it and plan on drinking and don't care what anyone says. You all plan on killing me just like [name of family member] by not letting me have what I want." RN #2 indicated she counseled the resident on the risks and consequences and that the resident told her he planned on drinking it anyway. When asked, the resident did give the cup to her. RN #2 also indicated that the resident had been found on numerous occasions with drinks and food in his room and had been seen consuming them and that because his family member continued to give him change to go to the snack machines when he asks for it, it was a running battle and challenge with the resident to be safe.</p> <p>During an interview with the resident on 4/29/14 at 10:30 a.m., the resident indicated he wanted to still eat and drink and was well aware of the consequences and that he tended to cough it up later, but insisted he was going to do as he pleased and wishes everyone would stop pestering him about it and taking the item away from him.</p> <p>3.1-4(d)</p> |               |   |                      |

|   |  |   |   |  |  |   |  |
|---|--|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                  |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155668 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                         |  | X3) DATE SURVEY COMPLETED<br><br>04/30/2014 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>DIVERSICARE OF PROVIDENCE LLC |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4915 CHARLESTOWN RD<br>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   |  |   |  |
| F000157<br>SS=D   | <p>483.10(b)(11)<br/>NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br/>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 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 record review and interviews, the facility failed to notify the physician in a timely manner when a resident developed edema and a fluid-filled blister on the leg which subsequently required</p> | F000157   | 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 on resident #76 and resident #83. 2) | 05/28/2014   |  |   |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                  |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155668 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                         |  | X3) DATE SURVEY COMPLETED<br><br>04/30/2014 |  |
|---|--|---|---|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>DIVERSICARE OF PROVIDENCE LLC |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4915 CHARLESTOWN RD<br>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>antibiotic treatment (Resident #76) and when a resident initially was noted to have a significant weight loss in a month's time and of the results of weight monitoring per physician order.(Resident #83). This deficient practice affected 2 of 4 residents reviewed for physician notification.</p> <p>Findings included:</p> <p>1. Review of the clinical record for Resident #76, on 4/24/14 at 9:00 a.m., indicated the resident had a diagnosis which included, but was not limited to: Cellulitis.</p> <p>A nursing note, dated 4/6/14 at 10:18 p.m., indicated: "Small fluid filled blister on left lower extremity. Legs continue to have edema red in color and cool to touch. Supervisor made aware."</p> <p>The next nursing note, dated 4/10/14 at 4:23 p.m., indicated "New orders for Keflex [an antibiotic] 500 mg TID [3 times a day] x [times] 7 days r/t [related to] cellulitis in right lower extremity...resident's legs are very edematous with 3+ edema. Very large fluid filled blister to right lower extremity. Lower extremities are red and warm to the touch. Skin is dry and scaly [sic]." This notification to the physician</p> |   | <p>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. Facility will complete a 100% audit of residents with blisters or significant weight loss to verify physician notification has occurred. 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 will be in-serviced on timely physician notification. Director of Nursing or Designee will audit 100% of significant weight loss and residents with blisters to verify timely physician notification weekly for one month, monthly for three months and then quarterly for the remainder of the year. 4) Director of Nursing or Designee will audit 100% of significant weight loss and residents with blisters to verify timely physician notification weekly for one month, monthly for three months and then quarterly for the remainder of the year. Findings will be reported to the QA committee.</p> |  |  |   |  |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155668 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>04/30/2014 |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>DIVERSICARE OF PROVIDENCE LLC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4915 CHARLESTOWN RD<br>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>was 4 days after the blister and edema appeared.</p> <p>During an interview with the Director of Nursing (DON) on 4/25/14 at 1:45 p.m., she indicated she did not have a policy which addressed "MD [Physician] Notification of Changes." She indicated that the nurses would just notify the MD whenever a change in medications or treatment was needed or labs out of value.</p> <p>2. Review of the clinical record for Resident #83 on 4/24/14 at 2:16 p.m., indicated the resident had diagnoses which included, but were not limited to: late effect hemiplegia [stroke], muscle weakness, abnormal glucose, dysphagia, and gastroesophageal reflux disorder.</p> <p>The weights indicated that on 3/3/14, the resident was observed to have had a 22.6 pound weight loss since the February weight of 160 pounds. A re-weight on 3/5/14 indicated the weight to be 137.6 pounds.</p> <p>A nursing note, dated 3/12/14 at 12:33 p.m., indicated "Resident has had a 22# weight loss this month due to possible wheelchair equipment discrepancies. MD notified and awaiting a return call at this</p> |               |   |                      |

|   |   |   |   |  |  |   |  |
|---|---|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                  |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155668 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                         |  | X3) DATE SURVEY COMPLETED<br><br>04/30/2014 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>DIVERSICARE OF PROVIDENCE LLC |   |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4915 CHARLESTOWN RD<br>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>time."<br/>- "12:49 p.m. - Resident is added to NAR [Nutrition At Risk] with weekly weights."<br/>- "4:29 p.m. - Spoke with MD related to weight loss and MD states to monitor her weight and reweigh her in a week and then notify her weight to MD and will evaluate at that time."</p> <p>Review of the March nursing notes indicated the physician was not notified until 3/12/14 - 9 days after the weight variance was noted.</p> <p>A re-weight on 3/18/14 was 138 pounds. Documentation was lacking of the physician having been notified again per his order of the weight continuing to be low.</p> <p>On 4/25/14 at 8:30 a.m., the DON presented a copy of the facility's current policy titled "Weight Variances." Review of this policy at this time included, but was not limited to: "Policy: all residents' weights will be monitored monthly or more often as indicated by the resident's condition, physician orders, etc. Procedure:...4. The nurse will report significant weight variances to the physician,...7. Before recording each weight in the medical record, the night nurse will double check that:.b...the</p> |   |   |  |  |   |  |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155668 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>04/30/2014 |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>DIVERSICARE OF PROVIDENCE LLC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4915 CHARLESTOWN RD<br>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 |
|--------------------|---|---------------|---|----------------------|
| F000279<br>SS=D    | <p>physician has been notified...."</p> <p>3.1-5(a)(2)<br/>3.1-5(a)(3)</p> <p>483.20(d), 483.20(k)(1)<br/>DEVELOP COMPREHENSIVE CARE PLANS<br/>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services</p> |               |   |                      |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155668 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>04/30/2014 |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>DIVERSICARE OF PROVIDENCE LLC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4915 CHARLESTOWN RD<br>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>that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interviews, the facility failed to develop a care plan which addressed a resident's non-compliance with his NPO (nothing by mouth) status (Resident #139) and when a resident developed increased edema with a large blister on leg (Resident #76). This deficient practice affected 2 of 9 resident care plans reviewed.</p> <p>Findings included:</p> <p>1. Review of the clinical record for Resident #139 on 4/28/14 at 11:00 a.m. indicated the resident was admitted to the facility on 12/2/13 and had diagnoses which included, but were not limited to: malignant neoplasm esophagus and gastroesophageal reflux disorder.</p> <p>Nursing notes between 12/16/13 and 4/29/14 indicated several entries in which the resident was observed consuming various food and beverage items despite having a NPO order.</p> <p>During an interview with the resident on 4/29/14 at 10:30 a.m., the resident indicated he wanted to still eat and drink</p> | F000279       | <p>1)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A care plan has been put into place for resident # 139 related to noncompliance with NPO diet. A care plan has been put into place for resident #76 related to the blister. 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. Director of Nursing or Designee will complete 100% audit for care plans for any residents with non-compliance with their NPO diet and residents with blisters. 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 Social Services will be in-serviced on putting care plans into place when residents are non-compliant with their NPO diet and any new blisters. Director of Nursing or Designee will audit 100% of residents who are non-compliant with their NPO diet or have blisters to verify care plans are in place weekly for one month, monthly for three months and quarterly for the remainder of the year. 4) Director of Nursing or</p> | 05/28/2014           |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155668 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>04/30/2014 |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>DIVERSICARE OF PROVIDENCE LLC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4915 CHARLESTOWN RD<br>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>and was well aware of the consequences and that it causes him to cough, but insisted he was going to do as he pleased and wished everyone would stop pestering him about it.</p> <p>A 3/13/14 Care Plan for impaired swallowing associated with esophageal cancer and NPO status - addressed the resident receiving Tube Feedings, but not the resident's non-compliance and sneak eating.</p> <p>On 4/29/14 at 1:10 p.m., the DON (Director of Nursing) indicated it was the Social Worker's responsibility to implement a care plan when a resident was non-compliant with his/her plan of care regimen.</p> <p>At 11:45 a.m., the Social Worker presented a copy of the IDT (Interdisciplinary Team) [name of hospice] Care plan developed with the facility. Review of this care plan failed to address the resident's non-compliance with his diet. Review of the facility care plan on resident having difficulty making his own decisions r/t (related to) his medical condition also failed to address the resident's non-compliance.</p> <p>2. Review of the clinical record for</p> |               | <p>Designee will audit 100% of residents who are non-compliant with their NPO diet and any new blisters to very care plans are in place weekly for one month, monthly for three months and quarterly for the remainder of the year. Findings will be reported to the QA committee.</p> |                      |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155668 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>04/30/2014 |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>DIVERSICARE OF PROVIDENCE LLC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4915 CHARLESTOWN RD<br>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 #76 on 4/24/14 at 9:00 a.m. indicated the resident had a diagnosis which included, but was not limited to: Cellulitis.</p> <p>A nursing note dated 4/6/14 at 10:18 p.m. indicated: "Small fluid filled blister on left lower extremity. Legs continue to have edema red in color and cool to touch. Supervisor made aware."</p> <p>The next nursing note dated 4/10/14 at 4:23 p.m. indicated "New orders for Keflex [an antibiotic] 500 mg TID [3 times a day] x [times] 7 days r/t [related to] cellulitis in right lower extremity...resident's legs are very edematous with 3+ edema. Very large fluid filled blister to right lower extremity. Lower extremities are red and warm to the touch. Skin is dry and scaley [sic]." This notification to the physician was 4 days after the blister and edema appeared.</p> <p>During an interview with the resident on 4/21/14 at 2:44 p.m., the resident indicated she had a blister from edema in her legs and that this wound was weeping and hurt.</p> <p>Review of the care plans for Resident #76 failed to locate a care plan which addressed the resident's wound and</p> |               |   |                      |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155668 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>04/30/2014 |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>DIVERSICARE OF PROVIDENCE LLC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4915 CHARLESTOWN RD<br>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>edema.</p> <p>During an interview with the ADON (Assistant Director of Nursing) on 4/28/14 at 2:54 p.m., she indicated that whoever writes the order, would be the one to put the care plan into place.</p> <p>On 4/25/14 at 8:50 a.m., the DON presented a copy of the facility's current policy titled "Comprehensive Plan of Care". Review of this policy at this time included, but was not limited to:<br/>"...Policy Statement: It shall be the responsibility of each Interdisciplinary Team Member involved in the resident's care to provide input into the development, implementation, maintenance and evaluation of the resident's Plan of Care...Procedure: 1. Document: discipline responsible for implementing care plan approaches: date the problem is identified; date goal is set to be reached; approach or action planned to accomplish goal and date approach was initiated; initials of persons writing care plan...7. Identify new problems and determine approaches and set goals...."</p> <p>3.1-35(a)</p> |               |   |                      |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155668 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>04/30/2014 |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>DIVERSICARE OF PROVIDENCE LLC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4915 CHARLESTOWN RD<br>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 |
|--------------------|---|---------------|--|----------------------|
| F000282<br>SS=D    | <p>483.20(k)(3)(ii)<br/>SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interviews, the facility failed to ensure that when a resident experienced a significant weight loss within 30 days, the weight was verified and the Dietitian provided timely interventions. This deficient practice affected 1 of 3 residents reviewed for weight loss. (Resident #83)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #83 on 4/24/14 at 2:16 p.m., indicated the resident had diagnoses which included, but were not limited to: late effect hemiplegia (stroke), abnormal glucose, dysphagia, gastroesophageal reflux disease.</p> <p>Review of the weight records indicated the following:<br/>11/27/13 = 163.6<br/>1/5/14 = 159.7<br/>2/5/14 = 160<br/>3/3/14 = 137.4 (-22.6)<br/>3/5/14 = 137.6<br/>3/18/14 = 138<br/>3/23/14 = 142.0</p> | F000282       | <p>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 resident #83 although resident #83 has since been seen by the Dietician and is being followed in NAR. 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. Director of Nursing or Designee will complete a 100 % audit of weights to verify that any significant weight loss identified that the Dietician has been notified to review. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Nursing staff will be in-serviced on notifying Dietician when a significant weight loss has been identified. Director of Nursing or Designee will audit 100% of monthly weights to verify that the Dietician has been notified on any significant weights loss identified for one year. 4)How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what</p> | 05/28/2014           |

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                  |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155668 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                         |  | X3) DATE SURVEY COMPLETED<br><br>04/30/2014 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>DIVERSICARE OF PROVIDENCE LLC |  |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4915 CHARLESTOWN RD<br>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>4/6/14 = 139.4<br/>4/20/14 = 140.2</p> <p>A nursing note, dated 3/12/14 at 12:33 p.m., indicated "Res has had a 22# weight loss this month due to possible wheelchair equipment discrepancies. MD [physician] notified and awaiting a return call at this time."<br/>- "12:49 .p.m. - Resident is added to NAR [Nutrition at Risk] with weekly weights."<br/>- "4:29 p.m. - Spoke with MD related to weight loss and MD states to monitor her weight and reweigh her in a week and then notify her weight to MD and will evaluate at that time."</p> <p>There was no further documentation to indicate the physician had been notified of the weights as had been requested.</p> <p>A dietary note, dated 3/23/14 at 2:19 p.m., indicated: "Quarterly Review: Resident receives a regular mechanically altered diet with no milk/dairy products or eggs at breakfast. She utilizes a divided plate and sippy cups for hot beverages at meals. CBW [Current Body Weight] - 142# with a downward trend x's 30 days. No chewing or swallowing problems noted. Resident is able to make her needs known and able to feed herself after tray set-up. She prefers to eat in the</p> |   | <p>quality assurance program will be put into place. Director of Nursing or Designee will audit 100% of monthly weights to verify that the Dietician has been notified on any significant weights loss identified for one year. Findings will be reported to the QA committee.</p> |  |  |   |  |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155668 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>04/30/2014 |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>DIVERSICARE OF PROVIDENCE LLC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4915 CHARLESTOWN RD<br>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>dining room. No skin issues."</p> <p>A 3/25/14 care plan developed 3 weeks after the significant weight loss was noted indicated: "Potential alteration in nutrition related to diagnosis of senile dementia and dementia. Weight Stable." "Goal - Resident will have no significant weight changes thru next review." "Approaches: To monitor and obtain weights. To provide diet A/O [as ordered]. To monitor meal consumption."</p> <p>A 3/25/14 care plan also developed after the significant weight loss was noted indicated: "Potential alteration in nutrition related to she receives a mechanically altered diet. Dx [diagnoses] include: dysphagia, dementia and depressive disorder." "Goal: Resident to have no significant weight loss thru next review." "Approaches: To monitor and obtain weights. To provide diet A/O. To provide adaptive equipment. To monitor meal consumption."</p> <p>Review of the 3/27/14 Quarterly MDS [Minimum Data Set] Assessment indicated - supervision of one for cues and encouragement for eating; no gain or loss in weight; weight 142#.</p> <p>The NAR meeting minutes included:<br/>- 3/27/14 Weight 3/16 = 141.2, 3/23 =</p> |               |   |                      |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155668 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>04/30/2014 |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>DIVERSICARE OF PROVIDENCE LLC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4915 CHARLESTOWN RD<br>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>142; On Thera M (Vitamin)...Feeds self in dining room...Will continue to follow.</p> <p>- 4/8/14 - Wt 4/1 = 139.4. weight 4/6 = 139.4. Consumes about 77% of meals - feeds self. On Thera M and Vit B12...Will monitor x 1 more week as up 1% in 30 days for weight. No changes. Continue POC [Plan of Care]</p> <p>The facility was unable to provide any further NAR notes.</p> <p>During an interview with the Director of Nursing and the Administrator on 4/25/14 at 11:40 a.m., they indicated "We had 2 staff - a nurse and a CNA [certified nursing assistant] some time ago- who were using old w/c [wheelchair] weights which subsequently threw off the actual weights. We put the residents into NAR, monitored them weekly anyway."</p> <p>During an interview with LPN #2 on 4/28/14 at 3:00 p.m., she indicated that she was not sure why the resident had a weight loss in March other than the resident did not eat well. She indicated that the resident was not on any supplements even after she showed a significant weight loss.</p> <p>During an interview with the Dietitian on 4/29/14 at 9:15 a.m., she indicated that</p> |               |   |                      |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155668 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>04/30/2014 |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>DIVERSICARE OF PROVIDENCE LLC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4915 CHARLESTOWN RD<br>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>unless nursing notified her of the significant weight loss, she may not pick up on it until the NAR meetings which met Q (every) other week or during resident review. Documentation was lacking in the dietary notes of the dietitian having spoken to the resident regarding the noted weight loss. Documentation was also lacking of the Dietitian having been notified to evaluate the resident's weight loss when it was initially identified per facility policy.</p> <p>On 4/25/14 at 8:30 a.m., the DON presented a copy of the facility's current policy titled "Weight Variances". Review of this policy at this time included, but was not limited to: "Policy: all residents' weights will be monitored monthly or more often as indicated by the resident's condition, physician orders, etc. Procedure:...2. Weight variance: Calculate weight loss or gain every time a resident is weighed. Significant weight variance must be brought to the attention of the Dietitian. 3. Dietitian will review information, discuss with the resident, and document on the medical record. 4. The nurse will report significant weight variances to the physician, 5...Gross weight gains or losses will prompt a reweighing of resident to confirm the results....7. Before recording each weight in the medical record, the night nurse will</p> |  |  |  |
|--|--|--|--|--|

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155668 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>04/30/2014 |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>DIVERSICARE OF PROVIDENCE LLC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4915 CHARLESTOWN RD<br>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 |
|--------------------|---|---------------|---|----------------------|
| F000431<br>SS=D    | <p>double check that: a. Any gross weight variation has prompted a re-weigh. b. If gross gain or loss had indeed occurred, a dietary consult has been requested and the physician has been notified...."</p> <p>3.1-35(g)(2)</p> <p>483.60(b), (d), (e)<br/>DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for</p> |               |   |                      |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155668 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>04/30/2014 |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>DIVERSICARE OF PROVIDENCE LLC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4915 CHARLESTOWN RD<br>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>storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were properly stored and labeled. This deficient practice affect 6 of 8 medication carts and 4 of 4 medication storage rooms observed. (Resident #173, 29, 148, 64, 23, and 102).</p> <p>Findings include:</p> <p>A. On 4/24/14 at 9:28 a.m., the 300 unit medication cart was observed to have the following:<br/>--Resident #173 had two open vials of insulin that were undated.</p> <p>On 4/24/14 at 9:35 a.m., the 300 unit medication room was observed to have several bottles of bulk over the counter medications with no patient identifiers.</p> <p>In an interview, on 4/24/14 at 8:53 a.m., LPN #4 indicated, "If the insulin has not been opened it is stored in the refrigerator. When we open it can be 28 days out of the refrigerator. We sign [on</p> | F000431       | <p>1) What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; Medications for resident #173,29, 148, 64, 23 and 102 have been labeled correctly. All OTC medications will be removed from the medication rooms and disposed. 2) How other residents having the same deficient practice will be identified and what corrective action(s) will be taken. A 100% audit will be completed for proper labeling and storage. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Facility will remove house stock from the medication rooms. The medication carts with house stock medications will be removed. Pharmacy will provide all previous house stock medications. The pyxis will be used for emergencies or until medication arrives from the pharmacy. A letter has been sent to all responsible parties/family members from the Administrator advising them that effective immediately the facility has discontinued use of house</p> | 05/28/2014           |

|   |  |   |   |  |  |   |  |
|---|--|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                  |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155668 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                         |  | X3) DATE SURVEY COMPLETED<br><br>04/30/2014 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>DIVERSICARE OF PROVIDENCE LLC |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4915 CHARLESTOWN RD<br>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 vial] when its been opened. I do not see any open date on these vials."</p> <p>B. On 4/24/14 at 9:53 a.m., the 100 unit medication cart was observed to have the following:<br/>--1 bottle Flonase with no resident label.<br/>--1 tube of antibacterial cream with no resident label.</p> <p>On 4/24/14 at 10:11 a.m., the 400 unit medication cart was observed to have the following:<br/>--1 vial of phenergan with no resident label.<br/>--1 box of Myrbertric with no resident label.<br/>--1 bottle of over the counter B-12 vitamins with no resident label.</p> <p>On 4/24/14 at 10:20 a.m., the 100/400 unit medication room was observed to have several bottles of over the counter medications stored with out any resident label.</p> <p>C. On 4/24/14 at 10:29 the 600 unit medication cart was observed to have the following:<br/>--1 vial of Resident #29's Novolin insulin with no date to indicate when it was opened.</p> |   | <p>stock medications and these types of medications will be provided by the pharmacy. Licensed staff will be in-serviced on eliminating house stock and labeling/storage of medications. Director of Nursing or Designee will audit medications/medication rooms for proper labeling/storage monthly for one month, monthly for three months and then quarterly for the remainder of the year. 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 audit medications/medication rooms for proper labeling/storage monthly for one month, monthly for three months and then quarterly for the remainder of the year. Findings will be reported to the QA committee.</p> |  |  |   |  |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155668 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>04/30/2014 |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>DIVERSICARE OF PROVIDENCE LLC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4915 CHARLESTOWN RD<br>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>In an interview on 4/24/14 at 10:30 a.m., LPN #5 indicated, "[If the insulin] in the drawer we date it. [It can be used for ] 30 days then get a bottle [vial] out of the refrigerator. I'm not seeing a date on it, I don't give her this on my shift" Then LPN #5 put the the vial back in the medication cart.</p> <p>D. On 4/24/14 at 10:45 a.m., the 800 medication cart was observed to have the following:</p> <p>--1 box of over the counter eye drops for Resident #148. The manufacturer instructions indicated "1 or 2 drops in the eye." The package lacked documentation of the physician's order.</p> <p>--1 box of over the counter artificial tears for Resident #64 with manufacturer instructions indicating "1 or 2 drops in the eye." The package lacked documentation of the physician's order, the residents full name, or the physician.</p> <p>--1 box of over the counter eye drops for Resident #23 lacked documentation of the physicians order.</p> <p>--1 box of over the counter Mucinex with no labeling.</p> <p>In an interview on 4/24/14 at 10:55 a.m., LPN #6 indicated over the counter medications should be labeled with the residents name, physician, physician order, and date opened.</p> |               |   |                      |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155668 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>04/30/2014 |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>DIVERSICARE OF PROVIDENCE LLC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4915 CHARLESTOWN RD<br>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>On 4/24/14 at 11:00 a.m., the 600/800 unit medication storage room was observed to have 4 cans of beer, 1 jug of brown liquid, and 1 bottle of wine in the medication refrigerator.</p> <p>The medication storage room also had bulk storage of over the counter medications.</p> <p>E. On 4/24/14 at 1:51 p.m., the 700 unit medication cart was observed to have the following:<br/>--1 unopened vial of Novolog insulin for Resident #102.</p> <p>On 4/24/14 at 1:53 p.m., LPN #7 indicated, "Once its [insulin] is open we can keep it open for 28 days [in the medication cart], otherwise we keep it in the fridge. I didn't take it[insulin] out so it must've been [taken out] this morning."</p> <p>On 4/24/14 at 2:00 p.m., the 700/900 Unit medication room was observed to have several bottles of over the counter medications stored without any resident label.</p> <p>On 4/25/15 11:35 a.m., the Director of Nursing (DoN) indicated, the over the counter medications have always been stored in bulk in the medication storage</p> |               |   |                      |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                  |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155668 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>04/30/2014 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>DIVERSICARE OF PROVIDENCE LLC |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4915 CHARLESTOWN RD<br>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>rooms. She indicated, when a resident was prescribed an over the counter medication, the staff remove the medication from the storage room and write the residents name, date, physician, and physician order on the vial. She was unable to provide information as to the system in place to monitor the amount of over the counter medications in the storage rooms or a process to ensure safe storage.</p> <p>A copy of the policy titled, "General Dose Preparation and Medication Administration", was provided by the DoN on 4/24/14 at 3:25 p.m. The policy states, ..."Facility staff should enter the date opened on the label of medications with shortened expiration dates (e.g., insulins, irrigation solutions, ect.)...."</p> <p>A copy of the policy titled, "House Stock Medications", was provided by the DoN on 4/25/14 at 8:30 a.m. The policy states, ..."Facility should ensure that House Stock Medications are stored in a secure area, under proper storage conditions, inaccordance with Applicable Law and the State Operations Manual..."</p> <p>3.1-25(j)<br/>3.1-25(k)<br/>3.1-25(l)</p> |   |   |                      |   |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                  |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155668 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                         |  | X3) DATE SURVEY COMPLETED<br><br>04/30/2014 |  |
|---|---|---|--|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>DIVERSICARE OF PROVIDENCE LLC |   |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4915 CHARLESTOWN RD<br>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   |  |   |  |
| R000000   | 3.1.-25(m)<br>3.1-25(o)   |   |  |  |  |   |  |
| R000300   | <p>These deficiencies reflect state findings in accordance with 410 IAC 16.2-5. 410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date.</p> <p>Based on observation and record review, the facility failed to ensure medications were stored and labeled properly. This deficient practice affected 1 of 1 medication carts and 1 of 1 medication storage rooms observed.</p> <p>Findings include:</p> <p>On 4/24/14 at 9:53 a.m., the 100 unit medication cart was observed to have the following:</p> <p>--1 bottle Flonase with no resident label.</p> <p>--1 tube of antibacterial cream with no resident label.</p> <p>On 4/24/14 at 10:20 a.m., the 100/400</p> | R000000   |  |  |  |   |  |
|   |   | R000300   | <p>1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Items identified have had proper labeling added.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. Director of Nursing and Designee will completed a 100% audit for proper labeling and storage. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Facility will remove house stock from the medication rooms. The medication carts with house stock medications will be removed. Pharmacy will provide</p> | 05/28/2014   |  |   |  |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155668 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>04/30/2014 |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>DIVERSICARE OF PROVIDENCE LLC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4915 CHARLESTOWN RD<br>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>unit medication room was observed to have several bottles of over the counter medications stored with out any resident label.</p> <p>A copy of the policy titled, "House Stock Medications", was provided by the Director of Nursing on 4/25/14 at 8:30 a.m. The policy states, ..."Facility should ensure that House Stock Medications are stored in a secure area, under proper storage conditions, in accordance with Applicable Law and the State Operations Manual...."</p> |               | <p>previous house stock medications. The pyxis will be used for emergencies. A letter has been sent to all responsible parties/family members from the Administrator advising them that effective immediately the facility has discontinued the use of house stock medications and these types of medications will be provided by the pharmacy. Licensed staff will in-serviced on elimination house stock and labeling/storage of medications. Director of Nursing or Designee will audit medications/medication rooms for proper labeling/storage monthly for one month, monthly for three months and then quarterly for the remainder of the year. 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 audit medications/medication room for proper labeling/storage monthly for one month, monthly for three months and then quarterly for the remainder of the year. Findings will be reported to the QA committee.</p> |                      |