STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING _____ B. WING _____	**06/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF PROVIDENCE	**4915 CHARLESTOWN RD NEW ALBANY, IN 47150**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident's rights remained intact after a resident (Resident K), with intact cognition, was placed on a locked dementia unit with a wanderguard for 1 of 3 residents reviewed for resident rights. Findings include: On 6/18/20 at 3:30 p.m., Resident K was observed sitting in her room on the locked dementia unit with a wanderguard in place. She indicated she was moved to a room on the 400 hall. She had propelled herself in her wheel chair up to the front desk to get a pen and pencil. They came and got her and told he she had to move because her new room needed repairs. They then took her back to the locked unit. She denied any exit seeking and only wanted a pen and paper. She does not want to be back on the locked unit because she felt restricted. The clinical record for Resident K was reviewed on 6/18/20 at 3:50 p.m. [DIAGNOSES REDACTED]. The MDS (Minimum Data Set) quarterly assessment, dated 5/8/20, indicated the resident's cognition was intact. The BIMS (Brief Interview of Mental Status) assessment, dated 6/16/20, indicated the resident's cognition was intact. Review of the resident's advance directives, on 6/18/20 at 4:10 p.m., indicated the resident was her own responsible party. The social services progress note, dated 5/5/20 at 10:50 a.m., indicated the SSD (Social Services Director) was notified by staff the resident had been wandering. A wanderguard was suggested related to resident's impaired safety awareness and wandering off unit (200 hall). The daughter was to discuss a wanderguard bracelet and relocation of the resident to the 500 hall (locked dementia unit) because of her wandering. The daughter was agreeable and the resident was to be relocated to the dementia unit. The Nurse Practitioner note, dated 6/9/20 at 6:41 p.m., indicated the resident was seen and evaluated due to she wanted to go back to her previous room/hall. The resident was transferred to the dementia locked unit when she was acutely ill with a urinary tract infection that caused considerable confusion and exit seeking. The resident had not been exit seeking and was no longer confused and recommended to move the resident off of the dementia unit. The progress note, dated 6/10/20 at 11:43 a.m., indicated the plan was to move the resident off of the secured dementia unit on 6/12/20. The family was happy to hear the resident would be moving to a less restrictive environment and gave approval for the room move. The progress note, dated 6/12/20 at 10:00 a.m., indicated the resident relocated from the 500 hall (locked dementia unit) to the 400 hall. The progress note, dated 6/12/20 at 10:37 a.m., indicated the resident was relocated to the 500 hall on the locked dementia unit on this date. The progress note, dated 6/12/20 at 7:13 p.m., indicated the Memory Care Director (MCD) had been on her way to exit the building when she saw Resident K in the hallway headed towards the 500 hall with LPN (Licensed Practical Nurse) 6. Resident K had begun to cry and sat down in a nearby chair. It was later learned that Resident K had been informed she would be relocated to the locked dementia unit because she had caused the wanderguard alarm to sound off up by the front door. Resident K stated she had went up to the front of the building towards the front desk to get paper and a pen, but it was believed Resident K had been exit seeking. Resident K sat in a chair outside the 500 hall locked unit for about an hour and cried while multiple staff attempted to comfort her. When the MCD left, Resident K was sitting in a chair in her room on the 500 hall still crying. The progress note, dated 6/16/20 at 2:06 p.m., indicated Resident K had been crying off and on since being relocated back on the 500 hall. During an interview on 6/18/20 at 4:07 p.m., RN (Registered Nurse) 4 indicated she had been on the 300 hall, heard the alarm sounding, came off the hall and saw Resident K with the receptionist. RN 4 never saw the resident at the front door, just by the desk with the receptionist. During an interview on 6/18/20 at 4:10 p.m., Receptionist 7 indicated the resident had come up to the front of the building for a pen or pencil. The resident had not gotten to her desk when staff turned her around. During an interview on 6/18/20 at 4:18 p.m., the MCD indicated on Friday, 6/12/20, she was getting ready to leave around 5:00 p.m. when she saw Resident K being ushered towards the memory care unit. LPN 6 thought she was trying to leave the facility. When Resident K realized she would be going on the locked unit, she began to cry. During an interview on 6/18/20 at 4:26 p.m., LPN 6 indicated she heard the wanderguard alarm sounding. As she was coming up from around the 200 and 300 hall corridor, she was told Resident K was getting a pencil and paper. LPN 6 then received a message to take her back to the locked unit. LPN 6 did not see Resident K trying to exit the facility. During an interview on 6/19/20 at 12:40 p.m., the Social Services Director indicated on 5/5/20, she was notified by staff that Resident K had been exit seeking off of the 200 hallway at which time a wanderguard was placed due to her dementia and her safety. She was moved off the unit on 6/12/20 and had attempted to leave the facility and was then placed back on the dementia unit. On 6/18/20 at 2:20 p.m., the Executive Director provided a current copy of the Document titled Resident Rights & Quality of Life dated 3/13/20. It included, but was not limited to, Purpose .To enumerate the rights of .residents .It is the policy .that all residents .have the right to a dignified existence, self-determination This Federal tag relates to Complaint IN 453 3.1-3(a)
F 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure appropriate documentation was in place when a resident (Resident B) was transferred to the hospital for 1 of 3 residents reviewed for resident hospital transfer documentation. Findings include: The clinical record for Resident B was reviewed on 6/17/20 at 2:55 p.m. [DIAGNOSES REDACTED]. The progress note, dated 4/15/20 at 7:39 a.m., indicated the resident had an elevated temperature and a new order was obtained for a COVID-19 test. The progress note, dated 4/15/20 at 2:42, indicated the COVID 19 swab was obtained and sent to the hospital with pending results. The progress note, dated 4/16/20 at 6:23 a.m., indicated the resident had decreased oxygenation saturation with wheezing present. Oxygen was applied at 2 LPM (liters per minute) and his oxygenation increased to between 93% and 94%. The progress note, dated 4/16/20 at 6:26 a.m., indicated the resident's oxygenation saturation remained between 93% - 95%. The progress note, dated 4/17/20 at 11:50 a.m., indicated the physician and family were notified that the resident was positive for COVID-19 and permission was given to relocate the resident to a different room in the facility. There were no new orders. The clinical record lacked any other documentation after 4/17/20 at 11:50 a.m. There was no documentation pertaining to the resident's transfer. The hospital emergency room documentation, dated 4/19/20 at 12:45 p.m. indicated the resident was sent from a nursing facility due to increasing shortness of breath and [MEDICAL CONDITION] and was recently diagnosed with [REDACTED]. On 6/18/20 at 4:45 p.m., the Director of Nursing provided a current copy of the document titled Transfer & Discharge, dated November 1, 2016. It included, but was not limited to,

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.

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F 0622 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Procedure .may transfer a Resident for any of the following .The Resident's welfare and the Resident's needs cannot be met by the center .Documentation Requirements .Before .a transfer or discharge for one of the reasons set forth in this policy .shall document in the Resident's record the following .The basis for the transfer This Federal tag relates to Complaint IN 453 3.1-50(a)(2)