

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E657	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2015
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NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00181818 and IN00182289.</p> <p>Complaint IN00181818 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00182289 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: September 21, 22, 23, and 24, 2015</p> <p>Facility number: 000483 Provider number: 15E657 AIM number: 100273470</p> <p>Census bed type: NF: 20 Total: 20</p> <p>Census payor type: Medicaid: 20 Total: 20</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		
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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 0280 SS=D Bldg. 00	<p>QR completed by 34849 on September 29, 2015.</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> <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 record review and interview, the facility failed to ensure the plan of care was revised and updated following two falls with injuries for 1 of 10 residents reviewed for care plans. (Resident #1)</p> <p>Findings include:</p>	F 0280	<p>F280 -483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP On September 25, 20015, the interdisciplinary team reviewed and revised resident #1 fall prevention care plan. On October 1, 2015, all nursing staff was in-serviced on fall prevention, reviewing and revision of all residents fall care</p>	10/01/2015

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	<p>Review of the clinical record on 09/23/2015 at 8:25 A.M., indicated Resident #1 had diagnoses including, but not limited to, atrial fibrillation, coronary artery disease, hypertension, diabetes, and dementia. Resident #1's high risk for falls care plan, with a revision date of 07/21/2015, indicated a risk for falls due to standing and pushing his wheelchair. The interventions included, but were not limited to, "...coordinate with appropriate staff to ensure a safe environment with: Floors even and free from spills or clutter..."</p> <p>Review of the incident report dated 08/07/2015 at 3:45 P.M., indicated Resident #1 fell while attempting to get up out of his wheelchair without assistance. Resident #1 tripped over the foot rest on the wheelchair and acquired a "lump" on his left eye. (Fall #1)</p> <p>Review of the incident report, dated 09/17/2015 at 5:30 P.M., indicated Resident #1 fell in the hallway/dining room. Resident #1 was propelling himself in his wheel chair and fell to the floor. The resident landed face first striking his left forehead, left shoulder, and left hip on the floor resulting in a laceration and hematoma. The residents level of consciousness was lethargic/stupor; slow to respond.</p>		<p>plans. Nurses are responsible to review and revise resident fall care plans with each fall, and no less than quarterly. The director of nursing or her delegate will be responsible to review and investigate each fall to ensure all measures are in place to prevent further incidents. The director of nursing or her delegate will be responsible to maintain a incident log, including but not limited to falls. The CQI committee will review incident logs at each meeting, no less than quarterly.</p>	

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	<p>Resident #1 was sent out to the hospital following the incident. (Fall #2)</p> <p>During an interview, on 09/22/2015 at 7:45 A.M., Resident #1's family member indicated he had a history of falls and they were concerned with the uneven floors related to the recent fall.</p> <p>During an interview, on 09/23/2015 at 8:12 A.M., LPN (Licensed Practical Nurse) #4 indicated that on 09/17/2015, Resident #1 was propelling himself in his wheelchair, exiting the dining room. LPN #4 indicated Resident #1's wheelchair hit a dip in the floor and tipped forward. LPN #4 further indicated Resident #1 landed on the carpeting, face first, while his wheelchair remained on the linoleum by the medication cart.</p> <p>During an interview, on 09/23/2015 at 10:50 A.M., Resident #1 indicated he had fallen in the past when his foot caught on the wheelchair foot rest and again, in the dining room, after his wheelchair picked up speed in the dip on the floor and the front wheels of the wheelchair hit a strip of missing carpeting.</p> <p>During an observation on 09/21/2015 at 10:48 A.M., Resident #1 was having difficulties rolling his wheelchair over the ridge where the carpeting was</p>			

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	<p>missing.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 05/03/2015, listed a Brief Interview for Mental Status (BIMS) score of 14, indicating Resident #1 was alert and oriented. The MDS assessment further indicated Resident #1 "...required limited assistance, was not steady transferring from surface to surface, but was able to stabilize without staff assistance..."</p> <p>The most recent comprehensive MDS assessment, dated 08/28/2015, listed a Brief Interview for Mental Status (BIMS) score of 12, indicating Resident #1 was mildly cognitively impaired. The MDS assessment further indicated Resident #1 "...required extensive assistance, balance surface-to-surface transfer not steady, but able to stabilize without staff assistance..."</p> <p>The current "Resident Care Plan Policy" was provided by the Director of Nursing on 09/23/2015 at 4:22 P.M. The policy indicated, "...Additions and modifications will be made by each disciplinary team member to assist facility personnel in meeting the needs of the resident. Plans will be reviewed at least quarterly and revised at any time the condition of the resident changes...All disciplines are</p>			

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F 0323 SS=D Bldg. 00	<p>responsible for updating the plan of care to assure the plan represents the resident's current status."</p> <p>The plan of care for Resident #1 was not revised or updated following the falls that occurred on 08/07/2015 and 09/17/2015.</p> <p>3.1-35(c)(1)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to maintain an environment free of accident hazards, as evidenced by a resident fall with injuries related to the uneven floor, for 1 of 16 residents who can move about the facility independently. (Resident #1)</p> <p>Findings include:</p> <p>Review of the clinical record on 09/23/2015 at 8:25 A.M., indicated Resident #1 had diagnoses including, but not limited to, atrial fibrillation, coronary</p>	F 0323	<p>F 323 483.25(h)FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES On October 2, 2015, an environmental review of all flooring area was conducted by the director of maintenance. Non-skid adhesive strips will be applied to the sloped area in question by the dining room opening, no later than October 23, 2015. The environmental supervisor will be responsible to monitor non-skid adhesive strips during their monthly preventative maintenance review. CQI committee will conduct an environmental review, including flooring, no less than quarterly. CQI</p>	10/23/2015

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	<p>artery disease, hypertension, diabetes, and dementia. A comprehensive MDS (Minimum Data Set) assessment, dated 08/28/2015, listed a BIMS (Brief Interview of Mental Status) score of 12, indicating Resident #1 was mildly cognitively impaired. The MDS assessment further indicated that Resident #1 "...required extensive assistance, balance surface-to-surface not steady, but able to stabilize without staff assistance..."</p> <p>Resident #1's "high risk for falls care plan", with a revised date of 07/21/2015, indicated a risk for falls due to standing and pushing his wheelchair. The interventions included, but were not limited to, "coordinate with appropriate staff to ensure a safe environment with: Floors even and free from spills or clutter..."</p> <p>Review of the incident report, dated/timed 09/17/2015 at 5:30 P.M., indicated Resident #1 fell in the hallway/dining room. Resident #1 was scooting in his wheel chair and fell to the floor. The resident landed face first, striking his left forehead, left shoulder and left hip on the floor, resulting in a laceration and hematoma. The resident's level of consciousness after the fall was "...lethargic/stupor; slow to respond..."</p>		will review all incidents and environmental areas which may contribute to any falls, no less than quarterly.				

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	<p>Resident #1 was sent out to the hospital.</p> <p>On 09/21/2015 at 10:48 A.M., Resident #1 was observed having difficulties rolling his wheel chair over the ridge where the carpeting was missing.</p> <p>During an interview, on 09/22/2015 at 7:45 A.M., Resident #1's family member indicated they were concerned with the uneven floors related to the resident's recent fall. The family member indicated Resident #1 had difficulty maneuvering his wheel chair with the dip in the floor.</p> <p>During an interview, on 09/23/2015 at 8:12 A.M., LPN (Licensed Practical Nurse) #4 indicated Resident #1 was propelling himself in his wheelchair, exiting the dining room. LPN #4 indicated Resident #1's wheelchair hit the dip in the floor and tipped forward. LPN #4 further indicated Resident #1 landed on the carpeting face first while his wheel chair remained on the linoleum by the medication cart.</p> <p>During an interview, on 09/23/2015 at 10:50 A.M., Resident #1 indicated he had fallen after his wheelchair picked up speed in the dip on the floor and the front wheels of the wheelchair hit the strip of missing carpeting.</p>			

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F 0458 SS=D Bldg. 00	<p>During an interview, on 09/23/2015 at 4:12 P.M., the Maintenance Director indicated there were no current plans for any floor repairs.</p> <p>The current facility policy, titled "Fall Risk and Post Fall Assessment", was provided by the Social Services Director on 09/23/2015 at 3:04 P.M. The policy indicated, but was not limited to, the following: "...the purpose was to identify treatable conditions and improve the overall quality of life for the resident. ...Revise the care plan to include all new fall interventions..."</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p> <p>483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. Based on observation, record review and interview, the facility failed to provide at least 80 square feet (sq ft) per resident for 2 of 11 resident rooms in the facility. (Rooms 1 and 3)</p>	F 0458	<p>F 458 483.70(d)(1)(ii)BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT The facility is requesting to continue the room waiver for room # 1 and 3</p>	10/11/2015

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F 0496 SS=D Bldg. 00	<p>Findings include:</p> <p>Review of the facility documentation of room size certification, provided by the Administrator on 09/22/2015 at 11:30 A.M., indicated the following room sizes, as observed on facility tour of being less than 80 square feet per resident:</p> <p>1. Room #1, *NF, had the capacity of 4 beds and was 305 square feet (sq ft), equaling 76 sq ft per resident.</p> <p>2. Room #3, *NF, had the capacity of 3 beds and was 217 sq ft, equaling 72 sq ft per resident.</p> <p>These room sizes were verified by the Administrator on 09/23/2015 at 2:30 P.M. During an interview at this time, the Administrator indicated she would like to continue with the room waiver.</p> <p>3.1-19(1)(2)(A) 3.1-19(1)(3) 3.1-19(1)(8)</p> <p>483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING</p>						

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	<p>Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.</p> <p>Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.</p> <p>If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.</p> <p>Based on record review and interview, the facility failed to ensure each employee had current licensure or certification, for 1 of 24 employees reviewed for employee records. (CNA #1) This practice had the potential to affect 20 of 20 residents currently</p>	F 0496	F 496 483.75(e)(5)-(7)NURSE AIDE REGISTRY VERIFICATION, RETRAINING On September 25, 2015, CNA #1's CNA certification was verified and effective on the Indiana License Verification web site. All license and certification will continue to be verified at the	09/25/2015

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	<p>residing in the facility.</p> <p>Findings include:</p> <p>On 09/24/2015 at 1:15 P.M., the employee records were reviewed. CNA (Certified Nursing Assistant) #1's license was found to be expired as of 04/04/2015. The "as worked" schedule from 09/06/2015 to 09/20/2015 indicated CNA #1 had worked the following dates on the 2 P.M. to 10 P.M. shift: 09/07/2015, 09/08/2015, 09/09/2015, 09/10/2015, 09/12/2015, 09/13/2015, 09/15/2015, 09/16/2015, 09/17/2015 and 09/18/2015.</p> <p>During an interview on 09/24/2015 at 1:35 P.M., the Administrator indicated CNA #1's license had been renewed by the BOM (Business Office Manager) that morning (09/24/2015) and she had been unaware that CNA #1's license had been expired since April, 2015. The Administrator further indicated CNA #1 had been working in the facility since the license had expired.</p> <p>During an interview on 09/24/2015 at 2:15 P.M., CNA #1 indicated she was not aware her license had expired in April, 2015. She further indicated she had worked five to six days a week, on the 2 P.M. to 10 P.M. shift, since her license</p>		<p>time of hire and HR personnel will be responsible to monitor renewal of all licensed or certified staff. CQI committee will be responsible to monitor license, certification and renewals of all employees, no less than quarterly.</p>				

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	had expired in April. 3.1-14(s)				