

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 09/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
---	--

(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 Recertification and State Licensure Survey.</p> <p>Survey Dates: September 23, 24, 25, 26 and 27, 2013.</p> <p>Facility number: 000483 Provider number: 15E657 AIM number: 100273470</p> <p>Survey team: Jennifer Carr, RN, TC Diana Sidell, RN Sunny Jungclaus, RN (September 27, 2013)</p> <p>Census bed type: NF: 19 Total: 19</p> <p>Census payor type: Medicaid: 17 Other: 2 Total: 19</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on October 4, 2013 by Cheryl Fielden, RN</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: 15E657	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
---	--

(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

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 09/27/2013	
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042			
(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			
F000248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, record review and interview, the facility failed to provide activities according to the best interest of the resident and as documented for 1 of 5 residents reviewed for activities. (Resident #6)</p> <p>Findings include:</p> <p>Resident #6's record was reviewed on 9/25/2013 at 5:20 p.m. Diagnoses included, but were not limited to, depressive disorder, seizures, anxiety, poor mobility, cervical stenosis, and profound mental retardation. Physician's orders for September 1, 2013 - September 30, 2013 indicated, "May participate in activities as planned and desired."</p> <p>"Initial Activity Assessment", dated 10/01/09 and signed by the Social Services Designee, LPN #1, indicated that current interests included: cards, games, crafts/arts, exercise, sports (ball toss), music, spiritual/religious</p>	F000248	F 248 Activities meet interests/needs of each resident The facility will provide an ongoing activities program that is designed to meet the interests and the physical, mental and psychosocial well-being of each resident. On October 12, 2013, the activity director reviewed resident # 6's initial Activity Assessment and a new Activity Assessment was completed to support changes in this resident's physical and mental decline which is related to but not limited to dx of Cerebral Palsy, poor mobility and cervical stenosis of his spine. The activity Director reviewed all residents' activity assessments and noted changes as needed. Resident #6 and all other residents Activities Care Plans will be reviewed and revised by October 26, 2013. Nursing staff was interviewed to the location of the resident's w/c storage while not in use. All staff states resident #6's w/c is stored in his room beside the closet closes to the door along with his hoyler lift to prevent obstruction of the walk way. The administrator visually verified w/c stored as	10/26/2013			

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 09/27/2013
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042		
(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>activities, trips, walking/wheeling outdoors, watching TV, watching movies, gardening/plants, talking/conversation, parties, social events, radio. "Preferred Activity Setting" indicated that the resident preferred activities in the following locations: "Day/activities room", "Inside facility/off unit", and "Outside facility". The location "Own room " was not checked as a preferred activity setting. Under "Resident Quotes - Adjustment to Placement", documentation indicated that Resident # 6's favorite time of year is "...when I get to go outside when it's warm."</p> <p>Resident #6's care plan, updated 7/2/13, indicated, "Activities: Strength. Resident participates adequately in activities of choice; Goal: Resident will continue to participate in activities of choice 3x's (times) wkly (weekly); Interventions: 1.) Resident will be reminded of daily activities. 2.) Resident will be praised for all efforts of participation. 3.) Resident will have activity calendar posted in room each month."</p> <p>During an interview with the Administrator and Director of Nursing (DoN) on 9/25/13 at 4:18 p.m., regarding Resident #6's participation</p>		<p>always in this location. Resident #6's activities care plan was updated to reflect the direction to staff to continue to conduct 1:1 visits throughout shift with resident in room to assist with wound healing intervention to turn resident side to side except at meal times – resident to be on coccyx area only to eat then turn on side and keep HOB elevated at 30 degrees – turn side to side to promote wound healing. Upon healing of sacral decubitus, resident #6 will be up in his will chair and passively participate in group activity no less than 3 days each week. The administrator interviewed activity assistant and investigated the statement no staff present during time period which 1:1 activity was stated as being done. On October 24th, 2013 the Activity assistant/CNA will be in-serviced on accurate documentation of activity events and 1:1 episodes. The Activity Director will be responsible to visually monitor times designated to complete 1:1 visits and group activities are completed as scheduled and documented accurately, no less than 1 day each week for 3 months then monthly thereafter. 1 CQI member other than the activities director will monitor completion of activities and 1:1 sessions are completed as scheduled and accurately documented, no less than once every quarter. CQI committee will review Activity</p>		

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 09/27/2013	
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042			
(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 activities, they were asked if he ever leaves his room. The DoN indicated, "He has a lot of interaction. The staff interacts with him a lot. His roommate interacts with him a lot. When they're feeding him he interacts a lot."</p> <p>A copy of Resident #6's "Events Calendar" for July - September, 2013 was provided by the Administrator on 9/26/13 at 2:52 p.m. "9:00 Coffee Social" was circled for the following dates in September: 2, 3, 4, 5, 6, 9, 10, 11, 12, 13, 16, 19, 20, 23 and 24. "1:00 Happy Hour" was circled the following dates in September: 4, 18 and 25. All dates circled had a notation of "1-1".</p> <p>A copy of Resident #6's "One on One Record" for the above activities was requested and provided by the Activity Aide on 9/26/13 at 4:54 p.m. Documentation dates provided included 2/1/2013 - 9/24/2013. The log contained columns for the following: "Date", "Time", "Location", "Mood (Did mood improve with 1-1)", "Activity", "Total Time", "Comments", and "Signature".</p> <p>Under the "Time" column, 108 of 109 times documented indicated "11:00 a.m." for every day documented.</p>		Directors and CQI members' findings, no less than quarterly.				

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 09/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
---	--

(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>Under the "Location" column, 109 of 109 locations documented indicated "His Rm (room)". Under the column "Activity", 5 of 109 activities indicated "nails."</p> <p>On 9/27/13, Resident #6 was observed at the following times:</p> <ul style="list-style-type: none"> - 11:00 a.m.: Resident #6 lying in bed. No staff in room. - 11:05 a.m.: Resident #6 lying in bed. No staff in room. - 11:09 a.m.: Resident #6 lying in bed. No staff in room. - 11:16 a.m.: Resident #6 lying in bed. No staff in room. - 11:17 a.m.: Activity Aide in nurse's station - 11:30 a.m.: Resident #6 received incontinence care by CNA #2 and CNA #3. - 11:31 a.m.: Activity Aide in dining room leading auction with 5 residents in attendance. <p>In an Interview conducted with the Activity Aide on 9/27/13 at 3:00 p.m., she was asked if Resident number #6 had participated in any activities since the activity "talked" was documented on the "One on One Record" on 9/24/13 at 11:00 a.m. She indicated, "Yes. Today. I cut his nails and talked. Do you want me to update it</p>			

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 09/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
---	--

(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 get you copies?" The Activity Aide returned at 3:08 p.m. with copies of the same document previously provided on 9/26/13 at 4:54 p.m. with an additional row as follows:</p> <ul style="list-style-type: none"> - Under the column "Date", the document indicated "9/27/13" - Under the column "Time", the document indicated "11 AM" - Under the column "Mood (Did mood improve with 1-1)", the document indicated "Kliped [sic] Nails talk" - Under the column "Activity", the document indicated "talked" - Under the column "Total Time", the document indicated "15 min dddddddd3ew (minutes)" - Under the column "Comments", the document indicated "Smiled" - Under the column "Signature", the Activity Aide's signature was noted. <p>The Activity Aide confirmed that she was the one who has performed, documented, and signed for all activities on the "One on One Record" provided for Resident #6. When asked specifically "Did you do it today (9/27/13) at 11 a.m. for 15 minutes?", she indicated, "Yes."</p> <p>When asked why the activities circled</p>			
--	--	--	--	--

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 09/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
---	--

(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 the "Events Calendar" are not noted on the "One on One Record", she indicated that she is not required to document events noted on the "Events Calendar" on the "One on One Record."</p> <p>LPN #1, Social Services Designee, was interviewed regarding Resident #6's activities on 9/27/13 at 7:45 p.m. She indicated that he gets up in a chair "sometimes." She indicated that he "doesn't watch much t.v...it triggers behaviors." She further indicated, "He 'sometimes' goes outside....In summer he goes out if he's up in his wheelchair".</p> <p>During multiple random and intentional observations during 5 of 5 survey dates on consecutive days September 23rd through September 27th, 2013, Resident #5 was not observed outside of his room or up in a chair. There was no wheelchair noted at his bedside for 5 of 5 consecutive survey dates. Neither his television, nor his radio was observed to be on for 5 of 5 consecutive survey dates. No documentation was found to indicate that the resident has been up in a chair or outside in any activity documentation or nursing notes throughout his record.</p>			

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 09/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
---	--

(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
	3.1-33(a) 3.1-33(b)(1) 3.1-33(b)(2) 3.1-33(b)(9) 3.1-33(c)			

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 09/27/2013
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042		
(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	
F000250 SS=E	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>A. Based on record review and interview, the facility failed to provide medically related social services to attain and maintain the highest practicable well-being of each resident in that Residents #7, #2, and #3 had no follow up from social services after an episode of behaviors. This affected 3 of 3 residents reviewed for medically related social services. (Resident's #2, #3 and #7)</p> <p>B. Based on record review and interview, the facility failed to provide the services of a qualified social service consultant for at least 4 hours per month. This had the potential to affect all 19 residents residing in the facility.</p> <p>Findings include:</p> <p>A. 1. Resident #7's record was reviewed on 9/26/13 at 10:13 a.m. The record indicated Resident #7 was admitted with diagnoses that</p>	F000250	F 250 Provision of Medically related Social Service The Social Service Designee reviewed nurses notes indicated in this report, conducted follow up interviews with resident # 7, # 3 and # 2, and nursing staff related to entries. All residents were interviewed for an opportunity to discuss and resolve any areas which they have concerns or problems. Behavioral care plans for resident #7, 3# and #2 were reviewed and revised as necessary by the social service designee. The social service designee and the administrator reviewed the facility policy and procedure on interventions for residents exhibiting negative behaviors which include direction in reporting of behaviors appropriately. All staff will be in-serviced on effective interventions to resolve negative behaviors of residents, by October 26, 2013. The facility has contracted with Green Tree & Associates which will provide 4 hours of social service consulting each month and individual therapy session to residents who are able and agree to participate. Social Service Designee will be responsible to conduct weekly	10/26/2013	

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 09/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
---	--

(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>included, but were not limited to, high blood pressure, major depressive disorder, severe scoliosis/lumbar spine, diabetes mellitus type 1, seizures, old stroke, contractures, peripheral neuropathy, blindness, high liver function tests, chronic pain syndrome, high blood fats, gastroesophageal reflux disease, and end stage chronic renal failure.</p> <p>Nurse's notes, dated 9/16/13 at 7:00 a.m., indicated: "Grievance form filled out d/t (due to) his inappropriate behavior during noc (night) shift. Res turned on his light so often it kept this writer and CNA from being able to do our routine work. Most of the time he needed very minor things. Turn fan off, turn fan on, get him milk & bowl, spoon so he can have cereal, he wanted feet "stretched". Many unnecessary things requested. Finally he asked to have 2 pieces of bologna put in microwave to soften it then roll it up like hot dogs and put mustard on it. He requested we look for pickles or pickle juice for him and a drink. I told him we were not able to continue making food for him that it was taking us away from other things that we had to do. He began screaming that he had asked only once to have food & was very agitated, he would not listen to</p>		<p>interviews with each resident to allow residents individual opportunity to discuss concerns or problems. Residents will continue to be given opportunity during Resident Council Meetings to discuss problems, concerns and recognition of positive effects. CQI will monitor all residents written concerns and monthly Social Service Consultant notes, no less than quarterly.</p>	

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 09/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
---	--

(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>reason. I offered to get his drink and look for the juice, but he was still yelling so this writer left the room. At that time he began turning light on & then off, then on - many times. I had told him earlier that we would be bathing a Resident who was going to hospital at 3:00 AM it was during this time that he turned light off & on. At one point he called the facility and hung up when this writer answered. Grievance/concern filled out at this time."</p> <p>Social Progress Notes, dated 9/6/13 through 9/23/13, failed to indicated an entry that this episode had been followed up by the Social Service Designee.</p> <p>On 9/27/13, at 5:04 p.m., the Social Service Designee, indicated she came into work that morning and she (the night nurse) told her that he was on his call light several times. She talked to him that morning, and he was upset; he does get upset if the girls can't stop and get him what he requests at that moment. It wasn't a complaint towards him, or a grievance, it is like how he was acting, this is a common thing he will do. She indicated staff will walk out of his room, and he will put his light on, they will tell him it will be a minute,</p>			

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 09/27/2013	
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042			
(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 not get down the hall and he is on his light again. He has called the facility and hung up. She said herself or the Administrator will investigate the situation and talk to the staff, see if he is all right, and he wasn't complaining and not in a bad mood. It is followed up in social service notes or on the actual grievance form.</p> <p>On 9/27/13, at 7:50 p.m., the Social Service Designee indicated the grievance form is not a part of the resident's record and she should have documented in the social service notes about Resident #7's behavior. She said she keeps a file on each resident about any grievances or behaviors.</p> <p>A. 2. Resident #2's record was reviewed on 9/27/2013 at 4:00 p.m. The record indicated Resident #2 had diagnoses that included, but were not limited to, heart disease, schizophrenia, glaucoma, and osteoporosis. The most recent quarterly Minimum Data Summary (MDS) was completed on 7/14/2013 and indicated that Resident #2's vision was "severely impaired." A Brief Interview for Mental Status (BIMS) was conducted at that time to determine her attention, orientation, and ability to register and recall new</p>						

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 09/27/2013
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042		
(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>information. She achieved a score of 12 of 13. Resident #2 was observed throughout the survey wearing dark glasses and utilizing a cane feel for objects around her to ambulate.</p> <p>Nurse's notes, dated 8/18/13 at 5:00 p.m., indicated: "Res (resident) states "[Resident #3] told me that this is [not] my room & that I have to move out". Also stated rm (room) mate called her names. Rm mate denies. Res was assured that she does [not] have to move out of rm & to report any neg. (negative) conversations [with] this rm mate."</p> <p>Social Progress Notes, dated 8/11/13 through 9/18/13, failed to indicated an entry that this episode had been followed up by the Social Service Designee.</p> <p>On 9/27/13, at 7:50 p.m., the Social Service Designee indicated she should have documented in the social service notes about Residents #2 and #3.</p> <p>A. 3. Resident #3's record was reviewed on 9/27/13 at 4:30 p.m. Diagnoses included, but were not limited to, obesity, chronic anxiety, depression, personality disorder, mood disorder, dementia with</p>				

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 09/27/2013	
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042			
(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>behavioral issues, and Parkinson's disease.</p> <p>A policy and procedure for "Social Services Role in Long Term Care", with a last review date of 2/9/13, was provided by the Administrator on 9/27/13 at 6:45 p.m. The policy included, but was not limited to, "Social Services will provide the medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The Social Service staff will assure that Residents are cared for in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life, dignity, and in respect in full recognition of his or her individuality...Grievances: All grievances will be investigated with appropriate interventions performed to resolve the problem when possible. A report will be given to the facility administrator who will assure resolution...Social Services will make interventions as needed to assure that the resident doesn't experience any psychosocial problems."</p> <p>B. The Employee Record form was provided by the Administrator on 9/23/13 at 11:40 a.m. The Employee</p>						

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 09/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
---	--

(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>Record form included a Social Service Designee, but failed to include a Social Service Consultant listed on the form.</p> <p>On 9/27/13, at 3:55 p.m., the Administrator indicated they have not had a Social Service Consultant for "awhile".</p> <p>3.1-34(a) 3.1-34(d)(3)</p>			

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 09/27/2013	
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042			
(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			
F000314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interview, the facility failed to ensure that a resident with a pressure ulcer received necessary treatment and services to promote healing and prevent new sores from developing. This affected 1 of 1 resident reviewed for pressure ulcers.</p> <p>Findings include:</p> <p>Resident #6's record was reviewed on 9/25/2013 at 5:20 p.m. Diagnoses included, but were not limited to, depressive disorder, seizures, anxiety, poor mobility, profound mental retardation and cervical stenosis. Pressure Ulcer was not listed among diagnoses, yet "Physician's Orders" for September 1, 2013 - September 30, 2013 indicated, "Apply betadine to coccyx Q (every) shift" and further investigation</p>	F000314	F 314 Treatment /Services to prevent/heal Pressure Sores The facility is requesting an IDR to remove this deficiency. The facility did provide treatment and services to prevent pressure areas and promote decubitus healing based on the following: Admission record verified resident was admitted with decubitus. Resident medical conditions are contributing factor with reoccurrence of decubitus area. The facility had a current treatment and care planning in place for the reoccurring sacral decubitus. Resident #6 has a pressure reduction mattress in place. Resident attending physician has provided documentation dated 9/30/2013 that the reoccurring sacral decubitus is "tertiary" compared to other medical complications for this resident. (See uploaded information – Resident #6) The facility long term medical director has provided written verification	10/26/2013			

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 09/27/2013
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042		
(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>revealed Resident #6 has an on-going pressure ulcer to his coccyx. Resident #6's most recent MDS assessment provided a Brief Interview for Mental Status (BIMS) score of 0. His previous "Pressure Wound Risk Assessment" scores, dated 8/20/12, 11/20/12 and 2/20/13, were 9. The "Pressure Wound Risk Assessment" dated 5/20/13 was not completed or scored.</p> <p>An interview with the Director of Nursing (DoN) was conducted on 9/24/13 at 11:27 a.m. She was asked if Resident #6 currently had one or more pressure ulcers. She replied that he did not. Further record review revealed a telephone order dated 9/14/13 which indicated, "L (left hip) = cleanse pressure area with soap & (and) water Apply Silvadene Q (every) shift." Under "Indication-DX (diagnosis)", "Pressure area redened [sic] swollen (Big tub) 7cm/4cm" was written. Another telephone order dated 9/15/13 indicated, "Cleanse area on Rt (right) hip with soap & (and) H2O (water) apply Triple Antb. (antibiotic) oint. (ointment) QS (every shift) & (and) PRN (as needed) until healed - area D/T (due to) tape". Additionally, Physician's Orders for September 1, 2013 - September 30, 2013 indicated, "Apply betadine to</p>		<p>dated 10/15/2013 that the facility is not at fault for the reoccurring sacral decubitus of resident #6 and that the facility provided above average care to this resident. The facility sent resident out for evaluation of surgeon which specializes in wound care – dated 10/15/2013. The resident was placed on a required hourly turn and reposition schedule with resident only on coccyx area for meals to heal decubitus area. This plan included staff requirement to place resident on back at the time meal tray is served and to immediately place resident on side after feeding with the HOB elevated no less than 30 degrees. No improvement noted with 9/26/2013 addition of dietary recommendation of double protein with meals or change in treatment which are sited as deficiency which prevented healing- area currently stage III d/t slough tissue. No improvement to wound noted with the insertion of a Foley catheter for wound care management on 09/30/2013. No improvement noted with the October 02, 2013 change of treatment to coccyx area – apply protective petroleum based barrier cream to good tissue around wound edges – apply Santyl cream to wound bed – cover with 2X2 gauze pad- area currently stage III d/t slough tissue. No improvement noted with evaluation of attending physician. No improvement noted</p>		

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 09/27/2013
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042		
(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>coccyx Q (every) shift".</p> <p>In an interview with LPN #1 on 9/24/13 at 3:05 p.m., she indicated that any documentation regarding skin conditions or treatments are located in the "skin book" and that any treatments are located under physician's orders. LPN #1 produced Resident #6's "Skin Condition Report". Documentation was as follows in the flow sheet provided:</p> <p>"Date: 9/3/13; Date of Onset: (blank); Location: coccyx; Type: 1 (Pressure Ulcer); Stage Ulcers: 2; Wound Size: Length: 2cm Width: 0.5cm Depth: 0.1cm; Sinus Tract/Undermining Y/N: 0; Tunneling/Depth: 0; Color/Odor: 0; Wound Description/Pain: Pink wound bed</p> <p>Date: 9/14/13; Date of Onset: (blank); Location: coccyx; Type: 1 (Pressure Ulcer); Stage Ulcers: 2; Wound Size: Length: 0.8cm Width: 0.4cm; Depth: 0.1cm; Sinus Tract/Undermining Y/N: N; Tunneling/Depth: N; Color/Odor: 0; Wound Description/Pain: Pink</p> <p>Date: 9/14/13; Date of Onset: (blank); Location: Lt (left) hip; Type: 1 (Pressure Ulcer); Stage Ulcers: 1; Wound Size: Length: 7.5 Width: 4; Depth: Raised 1; Sinus</p>		<p>with evaluation of surgeon specializing in wound management The director of nursing will be responsible to request an update on all wound areas, including any new development of any impaired skin integrity. On October 14, 2013, Nursing staff were in-serviced on wound prevention, treatment (which included not applying tape to any area that does not state secure with tape) and staging. The facility wound consultant unofficially assessed the wound of resident #3, prior to in-service. Resident #6 legal guardian services were contacted to request applying for Medicare for this resident to allow in house wound consulting which would prevent resident from going out of facility with stretcher transport which could have worsening effect on current wound. Diana Davis with Sentry Services - Legal guardian Services states "we have tried and he does not qualify for Medicare because he has never worked. The facility will attempt applying for Medicare for this resident to allow in- house wound consulting services. The administrator requested to pay for consulting services, but the wound consultant nurse states that is not allowed by her company policy. The administrator has requested that attending physician document on progress note all current and previous Hx of decubitus on each</p>		

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 09/27/2013	
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042			
(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>Tract/Undermining Y/N: N; Tunneling/Depth: N; Color/Odor: 0; Wound Description/Pain: Red"</p> <p>Above the flow sheet and documentation noted above, the following was written:</p> <p>"9/6/13 L (left) hip redened [sic], blanchable 6cm/4cm - repositioned; 9/11/13 L (left) hip 0 (no) redness."</p> <p>LPN #1 confirmed that she had signed all entries on the "Skin Condition Report" provided and noted above. She further indicated that the facility utilizes a wound nurse who visits once per month. However, Resident #6 is not under the care of the visiting wound nurse. LPN #1 was not able to clarify how long the resident had the pressure ulcer on his coccyx, what the treatment was, or why it had not been documented in 10 days.</p> <p>During an observation with the Administrator on 9/26/13 at 4:01 p.m., CNA #1 and CNA #2 performed incontinence care on Resident #6. The resident's skin was observed during the procedure and while repositioning him. A 1.5 inch x 2.5 inch excoriated, denuded area with irregular borders was observed on</p>		<p>visit. The administrator reviewed the policy and procedure for dietary recommendations. Dietary and Nursing will be in-serviced on policy and procedure of reporting and follow up of all consulting recommendations and on the facility's policy and procedure on Pressure Ulcer and Wound Management Program. The director of nursing or designee will be responsible to evaluate all wounds, no less than Q 2 weeks to ensure wound healing. The charge nurse is responsible to report immediately to the director of nursing and administrator all new wound areas or worsening of wound, at the time noted. CQI will monitor all skin impairments, no less than quarterly.</p>				

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 09/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
---	--

(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 #6's left upper buttocks/hip. Both CNAs and the Administrator indicated this was a result of tape, but were unable to recall what the tape was used for or when it occurred. The DoN later provided a copy of Resident #6's "Nurse's Notes" which indicated, "9-15-13 11 A (a.m.) Tape removed from coccyx area dsg (dressing) - 3cm x 2 cm area of superficial skin removed c (with) tape. Tx (treatment) to areas completed 0 (no) tape applied. Res (Resident) tolerated Tx (treatment) well....". However, no indication for any treatment or dressing other than the physician's order for betadine to coccyx could be located in Resident #6's medical record.</p> <p>During the same observation, a stage 3 pressure ulcer was observed at the crease of Resident #6's buttocks/coccyx approximately 1.5 inches long X 0.5 inches wide, cream-yellow in color. The Administrator was asked to stage the pressure ulcer and indicated that it was a "2" and had been there "awhile" and that it "comes and goes". No treatment was provided to the pressure ulcer. The Administrator indicated that CNAs do not provide pressure ulcer treatment with incontinence care.</p>			

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 09/27/2013	
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042			
(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>Admission Assessment indicated that resident was admitted with a pressure ulcer, but it was documented that it had healed. The Administrator could not locate a date of onset for the pressure ulcer on the coccyx. In an interview on 9/26/13 at 6:00 p.m., she indicated "I can't find anywhere where it (pressure ulcer to coccyx) was healed going back to 2012. I'll keep looking." No documentation was found related to any pressure ulcer(s) in "Physician's Progress Notes" after 2011. The Administrator was also unable to produce any documentation from the physician that the/any pressure ulcer(s) were/are unavoidable for the resident.</p> <p>The "Nurses Monthly Summary", dated 7/31/13 indicated, "Skin Assessment: Skin: Skin WDI (warm, dry, intact)...."</p> <p>"Nutritional Services Progress Note" dated 9/17/13 at 9:30 p.m. indicated, "Discussed skin issues with nursing and ADM (Administrator). (Resident #6) has a wound and is worse. Meal intake usually 100%. Albumin 3.15 (down arrow). Give milk all meals. Give double meats all meals to see heals skin and improved labs".</p>						

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 09/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
---	--

(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 9/26/13 at 4:37 p.m., the Administrator asked the Dietary Manager if she had received any new diet recommendations or orders for Resident #6. The Dietary Manager returned with a "Recommendations Worksheet - Registered Dietitian" dated 8/6/13 and indicated, "Not since August 6th." Upon seeing recommendation dated 9/17/13, the Dietary Manager retrieved a "Nutritional Recommendations Worksheet" dated 9/17/13 with the above recommendations noted from a file cabinet and provided to the survey team. She indicated that they receive recommendations, fax them to the doctor and "He always does what she says." When asked when Resident #6 would be started on the dietary recommendations dated 9/17/13, the Dietary Manager indicated "We'll fax those orders and as soon as we hear back from the doctor, we'll get them started." The Dietary Manager stated, "Well, I already faxed them. I'm just waiting to hear back from the doctor. The fax could be sitting on the charge nurse's desk. I don't know." When asked how the facility tracks nutrition recommendations and orders, the Administrator indicated that they do not print out fax transmission confirmations or stamp "FAXED" on documents; "She just knows she</p>			

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 09/27/2013
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042		
(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>faxed it." She further indicated that they would follow up. The Administrator produced a telephone order for the updated diet orders within the hour.</p> <p>The "Pressure Ulcer and Wound Management Program" Policy and Procedure was provided on 9/26/13 at 4:48 p.m. by the Administrator. It included, but was not limited to: "Purpose: To identify residents who are at risk for pressure ulcers and skin breakdown, to prevent pressure ulcers and skin breakdown, and to provide a guidelines for the appropriate nursing management of wound problems when they occur....Policy: It is the policy of the facility to implement an effective and comprehensive pressure ulcer prevention and wound management program to address broad aspects of the program including: initial and on-going assessments, preventative skin care, and appropriate skin and wound treatments to promote healing. Program Components: 1. Accurate, standardized assessments according to the specified frequency to identify risk and early indicators of potential skin breakdown. 2. Schedule for frequency of</p>				

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 09/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
---	--

(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>assessments</p> <p>3. Accurate and complete documentation of skin and wound assessments and appropriate preventive [sic] and therapeutic treatment orders.</p> <p>4. Input from appropriate disciplines via the referral and care planning process to provide comprehensive, coordinated approaches....</p> <p>6. Resident, family, and staff education to promote awareness of potential and actual skin problems, and the prevention and treatment plans.</p> <p>Standards:</p> <p>1. The resident will not develop pressure ulcers after admission unless unavoidable.</p> <p>2. The resident will be provided treatment in accordance with nationally published guidelines and practice standards to prevent breakdown and support the healing process.</p> <p>3. The resident will be provided a diet and other nutritional support to promote and aide the healing process.</p> <p>4. The resident will be encouraged to consume needed nutritional supplements consistent with care plan goals."</p>			

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 09/27/2013
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042		
(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	
	3.1-40(a)(2) 3.1-40(a)(3)				

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 09/27/2013
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042		
(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	
F000334 SS=D	<p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p>				

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 09/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
---	--

(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>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>Based on record review and interview, the facility failed to ensure that each resident's medical record included documentation that indicated that the resident or resident's legal representative was provided education regarding the influenza and pneumococcal immunization; and that the resident either received the influenza and/or pneumococcal immunization or did not receive the influenza and/or pneumococcal immunization due to medical contraindications or refusal. This affected 5 of 5 residents reviewed for immunizations.(Residents #2, #5, #6,</p>	F000334	<p>F 334 Influenza and Pneumococcal Immunizations</p> <p>The administrator has reviewed and revised the facility policy and procedure for Influenza and Pneumococcal Immunizations to ensure recommendations and regulations are followed. The facility will provide education information regarding the influenza and pneumococcal immunization to each resident and their legal representative. The facility will be offer influenza vaccine and Pneumococcal Vaccine to resident #2, #5, #6, #12, and #18 and all other residents unless the immunization is medically contraindicated or the</p>	10/26/2013

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 09/27/2013	
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042			
(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>#12 and #18)This deficiency had the potential to affect 19 of 19 residents.</p> <p>Findings include:</p> <p>A copy of the facility's "Influenza and Pneumococcal Disease Prevention Policy" was provided by the Administrator on 9/23/13 at 11:40 a.m. She indicated that resident immunization records were located under the History and Physical tab(H&P)in each resident's record. The policy included, but was not limited to:</p> <p>"...B. Employees and residents, regardless of length of stay, should receive the influenza vaccine.</p> <p>l)Influenza immunizations are offered to all residents and facility personnel from October 1 through March 31st annually, if available from the manufacturer. C. Residents should receive a pneumococcal vaccine unless they can recall prior vaccination or provide a record of immunization. l)If 65 years of age or older, a one-time revaccination is indicated if the resident was vaccinated more than 5 years previously and was under 65 years at the time of primary vaccination, unless medically contraindicated or the resident or the resident's legal representative refuses the second</p>		<p>resident has already been immunized, by October 26, 2013. All residents' medical record will be updated with acceptance or declination sheet indicating that they have received educational material and their personal response to the offer of Influenza and Pneumococcal Vaccination. The Influenza and Pneumococcal vaccine(s) will be administered when received. The facility will update individual resident's current Immunization record as immunizations are given. The director of nursing will continue to be responsible to ensure resident and their legal representatives are provide education on the Influenza and Pneumococcal Immunizations and ensure documentation is maintained in each individual resident medical record. A CQI member will be responsible to verification of completion of this task. CQI committee will review progress with in this quarter, then annually in September.</p>				

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 09/27/2013	
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042			
(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>immunization. D. Before offering the immunization, ...each resident or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization. I)...the resident or the resident's legal representative have the opportunity to refuse immunization. E. The resident's medical record includes, but is not limited to:)Documentation that the resident or resident's legal representative was provided education regarding the benefits and potential side effects of the influenza and/or pneumococcal immunization. 2)Documentation that the resident either received the influenza and/or pneumococcal immunization or did not due to medical contraindications or refusal....H. A permanent vaccination record is placed in each resident's chart indicating the resident's immunization status from the time of admission until discharge...."</p> <p>Resident #12's medical record was reviewed for immunization history on 9/26/13 at 10:40 a.m. Her most recent Brief Interview for Mental Status (BIMS) was conducted on 7/1/13 to determine her attention, orientation, and ability to register and recall new</p>						

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 09/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
---	--

(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>information. She achieved a score of 13 of 13.</p> <p>No immunization form was located under the H&P tab or anywhere else in the resident's record. The Administrator was unable to locate any additional immunization records. An "Influenza Vaccination Consent Form" was located with the resident's name indicated. No date was written at the top of the form where indicated. On the line indicating "Signature of Employee or Legal Guardian", "Res Refuses flu" was written. On the line indicating a date, "2012 Nov" was written. A copy of the form was requested and returned by the Administrator at 11:03 a.m. with the addition of the resident's signature noted on the signature line. The Administrator indicated, "She still wants to decline that, but I'm just going to document that here in the nursing notes." When asked if the facility policy required that the resident or legal representative sign a refusal, she indicated, "I'm not sure. Kim (the previous Director of Nursing) always took care of that." When asked whether Resident #6 was declining the influenza or pneumococcal immunization, as there was no other record of immunization in her record, the Administrator</p>			

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 09/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
---	--

(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, "That's what I went back to clarify; both."</p> <p>In an interview with Resident #12 on 9/27/13 at 10:34 a.m., she confirmed that she has refused immunizations since her admission to the facility.</p> <p>Resident #5's medical record was reviewed for immunization history 9/27/13 at 5:35 p.m. "Record of T.B. Tests and Immunizations" included no documentation under "Flu Vaccine (given annually)" or "Pneumonia Vaccine (given every 3-5 years)". No other documentation in resident record located regarding influenza and/or pneumococcal immunization and/or refusal and/or education.</p> <p>Resident #18's medical record was reviewed for immunization history 9/26/13 at 2:30 p.m. "Record of T.B. Tests and Immunizations" included no documentation under "Flu Vaccine (given annually)" box. To the side of the box, "Not in facility during flu season and res. declines" is written. No documentation in "Pneumonia Vaccine (given every 3-5 years)" box. To the side of the box, "2/8/12 offered + declined" is written. No other documentation in resident record located regarding influenza and/or pneumococcal immunization and/or</p>			

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 09/27/2013
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042		
(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>refusal and/or education.</p> <p>Resident #6's medical record was reviewed for immunization history 9/26/13 at 2:30 p.m. The "Record of T.B. Tests and Immunizations" indicated to the side of "Flu Vaccine (given annually)" box, "11/9/12 WB's - XXXX (4 initials) administers Flu Vaccine" with Administrator's signature. No additional documentation was located regarding this immunization, including manufacturer, lot number, expiration date or location of injection. Additionally, no documentation regarding education for the influenza immunization was provided. The last recorded pneumococcal immunization for Resident #6 was in June of 2006. There is no documentation regarding consent or education for this immunization.</p> <p>Resident #2's medical record was reviewed for immunization history on 9/26/13 at 2:30 p.m. The "Record of T.B. Tests and Immunizations" indicated that the last influenza immunization provided was 11/22/11. There was no documentation of consent or education provided for this immunization. There was no documentation regarding education or refusal for the 2012 influenza vaccine</p>				

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 09/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
---	--

(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>provided. The last pneumococcal vaccine was administered 3/7/06. There was no additional documentation provided regarding education or consent for this immunization.</p> <p>In an interview with the Administrator on 9/27/13 at 8:45 p.m., she indicated that the DoN is responsible for Influenza and Pneumococcal Disease Prevention.</p> <p>3.1-18(b)(5)</p>			

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 09/27/2013	
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042			
(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			
F000354 SS=E	<p>483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON</p> <p>Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.</p> <p>Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.</p> <p>The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.</p> <p>Based on record review and interview, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days per week for 19 of 34 days between 8/25/13 and 9/27/13. This had the potential to affect all 19 residents in the facility.</p> <p>Findings include:</p> <p>Nursing schedules, dated from 9/22/13 through 9/27/13, were provided by the Administrator on 9/23/13 at 8:30 a.m. Nursing schedules, dated from 8/25/13 through 9/21/13, were provided by the Administrator on 9/26/13 at 5:06 p.m.</p> <p>Nurse's schedules, dated 8/25/13</p>	F000354	F 354 Waiver-RN 8 consecutive hours 7 days/wk The facility will request an RN waiver. The facility will continue to seek register nurses to ensure that the facility uses the service of registered nurses for at least 8 consecutive hours a day 7 days a week. Help wanted ads have been place in local newspapers and on the Work Force One computer site. The administrator will be responsible to continue to seek services of a registered nurse. CQI will be responsible to review adequate staffing hours , no less than quarterly.	11/30/2013			

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 09/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
---	--

(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>through 9/8/13, indicated one RN (#1), who was also the Director of Nurses, on the schedules, with no times or dates that she was scheduled to work. Review of RN #1's time card, dated 8/26/13 through 9/7/13, indicated the following dates that had at least 8 consecutive hours of RN coverage: 8/26/13, 8/27/13, 8/28/13, 8/29/13, 9/3/13, and 9/5/13. This indicated a total RN coverage of 6 out of 14 days for this two week schedule.</p> <p>Nurse's schedules, dated 9/8/13 through 9/21/13, indicated the RN was scheduled Monday through Friday for both weeks. Review of the time cards for the days worked, indicated the following dates had at least 8 consecutive hours of RN coverage: 9/10/13, 9/12/13, 9/13/13, 9/17/13, 9/18/13, and 9/20/13. This indicated a total RN coverage of 6 days out of the 14 days for this two week schedule.</p> <p>Nurse's schedules, dated 9/22/13 through 9/27/13, indicated the RN was on the schedule for 9/23/13 and 9/27/13. Review of the time card for the days worked, indicated at least 8 consecutive hours on 9/23/13, 9/24/13, and 9/25/13.</p>			

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 09/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
---	--

(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 9/27/13 at 6:20 p.m., the Administrator indicated they "are missing RN coverage" and indicated the DON typically works from 10:00 a.m. to 6:30 p.m. The administrator provided time cards for the DON, who is the only RN on the schedule.</p> <p>3.1-17(b)(3)</p>			

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 09/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
---	--

(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
F000356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to ensure that staffing was posted daily. This affected all 19 residents in the facility and all resident's visitors for 5 of 5</p>	F000356	F 356 Posted Nurse Staffing Information The facility will post daily at the beginning of each shift the following information: Facility Name -Current date- The total number and the actual hours worked by Registered nurses,	10/21/2013

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 09/27/2013
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042		
(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>survey days.</p> <p>Findings include:</p> <p>During the initial tour on 9/23/13 at 8:38 a.m., no daily staffing was observed to be posted. A dry erase board was observed outside the nurse's station and it had a menu secured over the board with magnets.</p> <p>The daily staffing was not observed posted for each subsequent day of the survey, for 9/24/13, 9/25/13, 9/26/13, and 9/27/13.</p> <p>During an interview with the Administrator on 9/27/13 at 8:45 p.m., she indicated that she was not aware that staffing must be posted daily in a conspicuous location and that copies of those postings must be kept for 18 months. She further indicated that the Director of Nursing (DoN) was "working on the RN waiver; I don't know where she is with that."</p> <p>3.1-13(a)</p>		<p>licensed nurses, certified nursing assistants - Resident Census The facility will maintain the required information in an area easily accessible to the public for review for no less than 18 months. The charge nurse will be responsible to post required information at the beginning of their shift. The director of nursing will be responsible to visual monitor and ensure this is maintained in a location easily accessible to the public and that records are kept for no less than 18 months. CQI will monitor and review documentation, no less than quarterly.</p>		

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 09/27/2013	
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042			
(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			
F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>A. Based on observation, record</p>	F000441	F 441 Infection Control The facility will maintain a program	10/26/2013			

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 09/27/2013
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042		
(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>review and interview, the facility failed to provide resident care according to accepted standards of practice to prevent the spread of infection for 1 of 19 residents observed for infection control. (Resident #6)</p> <p>B. Based on record review and interview, the facility failed to develop an Infection Control Program under which it accurately maintained a record of incidents and corrective actions related to infections. This deficiency had the potential to affect all 19 residents in the facility.</p> <p>Findings include:</p> <p>A. Resident #6's record was reviewed on 9/25/2013 at 5:20 p.m. Diagnoses included, but were not limited to, depressive disorder, seizures, anxiety, poor mobility, profound mental retardation and cervical stenosis. Pressure ulcer was not listed as diagnoses, yet order for "Apply betadine to coccyx Q (every shift" and further investigation revealed Resident #6 has on-going stage III pressure ulcer to coccyx.</p> <p>During an observation with the Administrator on 9/26/13 at 4:01 p.m., CNA #1 and CNA #2 performed incontinence care on Resident #6.</p>		<p>which will prevent the development and transmission of disease and infection. A.) On October 24, 2013, all nursing staff will be in-serviced on infection control and then no less than annually. The director of nursing or delegate will be responsible throughout their shift to monitor and enforce hand washing prior to care, including observation of hand washing in nurse's station prior to tasks. All department supervisors will monitor infection control prevention is maintained throughout their shift. CQI Committee will monitor Infection Control no less than quarterly. B.) The administrator reviewed and revised the facilities Infection Control Program. On October 24, 2013, nursing staff will be in-serviced on Infection Control Program, including but not limited to accurately completion of "Antibiotic Usage Report" form, cross contamination and monthly review of infections. The nurse receiving the antibiotic order will be responsible for the accurate and full completion of the "Antibiotic Usage Report" form. The director of nursing or her delegate will be responsible for review of the monthly infection control report log. CQI will review and monitor Infection Control process, no less than quarterly.</p>		

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 09/27/2013
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042		
(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>Neither CNA was observed washing her hands prior to donning gloves. Resident #6 was in a supine position on the bed. CNA #2 pulled out a clear plastic bag with a wet washcloth inside it. She handed the wet washcloth to CNA #1, who wiped Resident #6's left eye from the inner corner to the outer corner. CNA #1 immediately repeated the same motion with the same portion of the washcloth. She then rotated to a different section of the washcloth and repeated wiping from the inner corner to outer corner of the left eye. CNA #1 was then observed rotating the same washcloth again and wiping the right eye from the inner corner to the outer corner with the same portion of the washcloth before rotating to another portion of the washcloth.</p> <p>CNA #2 was then observed cleaning Resident #6's groin area with the same washcloth before both CNA #1 and CNA #2 turned the resident over to clean a small light-colored bowel movement from his buttocks.</p> <p>In an interview with the Administrator at 5:31 p.m., she was asked why only one washcloth was used for the entire procedure. The Administrator indicated, "I thought there was more than one all in the same bag. One</p>				

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 09/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
---	--

(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>with soap; one with just water." When asked what the facility uses for incontinence care, the Administrator indicated, "We just use soap and water."</p> <p>B. The Director of Nursing (DoN) was interviewed on 9/25/13 at 3:04 p.m. She indicated, "In my opinion, they're an antibiotic bunch here. A lot of times, we don't get a culture if they're not showing a lot of signs and symptoms". She indicated that the pharmacy sends her a report at the beginning of each month for the previous month with all the medications utilized "so I can go back and see if my nurses are documenting the right way. I can look back any time."</p> <p>The "Antibiotic Usage Report" for August 2013 was provided on 9/25/13 at 3:23 p.m., by the DoN. Several columns were blank, including "Date of culture", "Is organism sensitive to antibiotic?", "Clinical signs of infection present?", and "Infection resolved?" Regarding tracking infections, the DoN indicated that she can "go on the web site and look for things in common." She further indicated, "If there was something we would expect to see it all over, because the same CNA who takes care of the resident in</p>			

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 09/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
---	--

(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>room 1 will take care of the resident in the other rooms. It wouldn't just be on one end of the hall. It would be all over".</p> <p>The facility's "Infection Control Policy" was provided by the Administrator on 9/25/13 at 10:13 a.m. The policy included, but was not limited to, the following:</p> <p>"Purpose: To establish methods and criteria, necessary within the facility and it's operation, to prevent and control infections and communicable diseases...Standards: 1. The facility has established an Infection Control Program which addresses all phases of the organization's operation to reduce or prevent the risks of nosocomial infections in residents and health care workers, including staff and immunization programs. 2. The Infection Control Program meets the guidelines of the U.S. Department of Health and Human Services' Centers for Disease Control and Prevention, CMS (HCFA), The Occupational Health and Safety Administration, local, state, and federal rules. 3. The Quality Assessment and Improvement Committee is responsible for monitoring the effectiveness of the program and continually improving</p>			

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 09/27/2013	
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042			
(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>outcomes....7. The program provides for the recording of each suspected infection and surveillance activities as they relate to individual resident infections. A log of suspected and actual infections is maintained on a day-to-day basis. (See Infection Report - Criteria Determination Policy.)....16. All facility personnel shall adhere to the Infection Control Program in the performance of their daily assignments...."</p> <p>In an interview with the Administrator on 9/27/13 at 7:45 p.m., she indicated, "The nurses do the sheets and the DoN is to put them on a spread sheet. I like to see the different infections". The facility did not provide the "Infection Report-Determination Policy" section of the Infection Control Policy.</p> <p>3.1-18(a) 3.1-18(b)(3)</p>						

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 09/27/2013	
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042			
(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			
F000458 SS=D	<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.</p> <p>Based on observation, record review, and interview, the facility failed to ensure that two resident bedrooms measured at least 80 square feet per resident in 2 of 10 sampled rooms. (Rooms 1 and 3)</p> <p>Findings included:</p> <p>On 9/27/13 at 6:00 p.m., the Administrator indicated they would continue the room size waiver for rooms 1 and 3, so they could place one more bed in room 1, and one more bed in room 3, when they needed to. The room waiver form was not completed. She provided the measurements for the two rooms, which were:</p> <p>*Room 1 NF was 301.63 square feet, and had 3 beds, to equal 100.54 square feet per bed. *Room 3 NF was 213.86 square feet, and had 2 beds, to equal 106.9 square feet per bed.</p> <p>3.1-19(1)(2)</p>	F000458	The facility requests a waiver for room 1 and room 3. State Surveyors told the administrator that they will put in the recommendation for room waivers. CQI will monitor room waiver received.	10/26/2013			

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 09/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
---	--

(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

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 09/27/2013	
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042			
(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			
F000514 SS=D	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>A. Based on observation, record review and interview, the facility failed to maintain complete and accurately documented weights in accordance with accepted professional standards of practice and their own policy and procedure; and maintain accurately documented activities records for 1 of 17 residents reviewed for medical records. (Resident #6)</p> <p>Findings include:</p> <p>A review of Resident #6's medical record was conducted on 9/25/2013 at 5:20 p.m. Diagnoses included, but were not limited to, depressive disorder, seizures, anxiety, poor mobility, profound mental retardation, paraplegia and cervical stenosis.</p>	F000514	F 514 Resident Records The administrator has reviewed the policy and procedure and accompanying forms for: Significant weight change, obtaining weights, group activities and 1:1 visits. All staff will be in-serviced on the complete and accurate documentation, including accurate times and correction process of documentation errors. Each Department supervisor will be responsible to review residents' medical records related to their department for accuracy and completion. CQI will review medical records for accurate completion, no less than quarterly.	10/26/2013			

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 09/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
---	--

(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>Physician's Orders for September 1, 2013 - September 30, 2013 indicated, "Weight with showers on Weds (Wednesdays) and Sat (Saturdays)."</p> <p>A copy of "Resident Weights 2013" for all facility residents for the months of January through September 2013 was provided by the Administrator 9/23/13 at 1:47p.m.</p> <p>The following were the only documented weights for Resident #6 during September, 2013:</p> <p>9/2/13: 196 9/6/13: 196 9/7/13: 197 9/11/13: 197 9/14/13: 197 9/16/13: 131 9/21/13: 132</p> <p>The following were the only documented weights for Resident #6 for March, 2013:</p> <p>3/7/13: 180 3/11/13: 162</p> <p>In an interview on 9/25/13 at 3:15 p.m. regarding the documented 66 pound weight loss between 9/14/13 and 9/16/13 and the follow-up</p>			

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 09/27/2013	
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042			
(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>documented weight of 132 on 9/21/13, she indicated, "Those are inaccurate....Those were never brought to my attention." She then asked, "Do you want me to have me weight him now?"</p> <p>The Administrator arrived at 3:25 p.m. with another binder containing "Resident Weights 2013" for the month of September for all facility residents. She indicated that facility staff likely transposed Resident #6's incorrect weight with another resident and pointed out that the weight of Resident #12 was similar to the one recorded for Resident #6. However, the dates and weights did not correlate and there were two incorrectly documented weights (9/16/13 and 9/21/13).</p> <p>In explaining the procedure for documenting weights, the Administrator indicated that the CNAs document weights in the CNA book; followed by the nurse 's transposes those weights into the Treatment Administration Record (TAR). The Dietary Officer/Business Manager then transposes those weights to a separate, "Continuing Quality Indicator" (CQI) spread sheet, which is identical to the CNA spreadsheet. The Administrator indicated "I rarely</p>						

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 09/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
---	--

(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>look at "CQI...only once in a while to see if there is any significant weight loss." She further indicated, "I promise you that is inaccurate documentation." When asked where the nutrition consultant finds reliable weights with so many documentation locations, the Administrator indicated, "She's been around so long, she knows where to look."</p> <p>When asked what the facility policy would be in the event that a sudden, significant weight loss would be noted, she indicated that she would expect staff to re-weigh and verify the weight.</p> <p>At 3:49 p.m., the DoN indicated, "His weight is 186." Written documentation of Resident #6's current weight was requested and provided on 9/26/13.</p> <p>At 4:18:29 p.m., the DoN provided a copy of "Food/Fluid Intake Record" for September, 2013 with the following averages (minus dinner for the evening): Breakfast: 98.8%; Lunch: 85%; Dinner 81.4%.</p> <p>A policy and procedure for "Significant Weight Loss", with a last review date of 2/9/13, was provided</p>			

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 09/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
---	--

(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
	by the Administrator on 9/27/13 at 2:55 p.m. The policy indicated, but was not limited to: " Policy: The goal of medical nutrition therapy (MNT) is to identify underlying causes or factors contributing to the significant unplanned weight loss, and intervene as appropriate to resolve the problem and stabilize the weight. Procedure: Appropriate members of the interdisciplinary team will: 1. Identify individuals with significant/severe weight losses ...1. a. Re-weigh the individual to assure an accurate weight. b. Compare current weight to usual body weight. Assess whether or not the weight loss was desirable (avoidable or unavoidable), and document accordingly. c. Interview the direct care givers for information on recent changes. d. Review the food intake records to estimate the average percentage of food/fluid intake in the past two to four weeks ...m. Document findings in the medical recordo. Place the individual on weekly weights for one month and review these weights weekly. p. Complete follow up documentation as needed "			

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 09/27/2013	
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042			
(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>Physician's orders for September 1, 2013 - September 30, 2013 indicated, "May participate in activities as planned and desired."</p> <p>A copy of Resident #6's "Events Calendar" for July - September, 2013 was provided by the Administrator on 9/26/13 at 2:52 p.m. "9:00 Coffee Social" was circled for the following dates in September: 2, 3, 4, 5, 6, 9, 10, 11, 12, 13, 16, 19, 20, 23 and 24. "1:00 Happy Hour" was circled the following dates in September: 4, 18 and 25. All dates circled had a notation of "1-1".</p> <p>A copy of Resident #6's "One on One Record" for activities was requested and received by the Activity Aide on 9/26/13 at 4:54 p.m. Documentation dates provided included 2/1/2013 - 9/24/2013. The log contained columns for the following: "Date", "Time", "Location", "Mood (Did mood improve with 1-1)", "Activity", "Total Time", "Comments", and "Signature".</p> <p>Under the "Time" column, 108 of 109 times documented indicated "11:00 a.m." for every day documented. Under the "Location" column, 109 of 109 locations documented indicated "His Rm (room)". Under the column "Activity", 5 of 109 activities indicated</p>						

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 09/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
---	--

(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>"nails".</p> <p>On 9/27/13, Resident #6 was observed at the following times:</p> <ul style="list-style-type: none"> - 11:00 a.m.: Resident #6 lying in bed. No staff in room. - 11:05 a.m.: Resident #6 lying in bed. No staff in room. - 11:09 a.m.: Resident #6 lying in bed. No staff in room. - 11:16 a.m.: Resident #6 lying in bed. No staff in room. - 11:17 a.m.: Activity Aide in nurse's station - 11:30 a.m.: Resident #6 received incontinence care by CNA #2 and CNA #3. - 11:31 a.m.: Activity Aide in dining room leading auction with 5 residents in attendance. <p>In an Interview conducted with the Activity Aide on 9/27/13 at 3:00 p.m., she was asked if Resident number #6 had participated in any activities since the activity "talked" was documented on the "One on One Record" on 9/24/13 at 11:00 a.m. She indicated, "Yes. Today. I cut his nails and talked. Do you want me to update it and get you copies?" The Activities Aide returned at 3:08 p.m. with copies of the same document previously provided on 9/26/13 at 4:54 p.m. with</p>			
--	--	--	--	--

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 09/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
---	--

(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>an additional row as follows:</p> <ul style="list-style-type: none"> - Under the column "Date", the document indicated "9/27/13" - Under the column "Time", the document indicated "11 AM" - Under the column "Mood (Did mood improve with 1-1)", the document indicated "Kliped [sic] Nails talk" - Under the column "Activity", the document indicated "talked" - Under the column "Total Time", the document indicated "15 min (minutes)" - Under the column "Comments", the document indicated "Smiled" - Under the column "Signature", the Activity Aide's signature was noted <p>The Activity Aide confirmed that she was the one who had performed, documented, and signed for activities for the "One on One Record" provided for Resident #6. When asked specifically "Did you do it today (9/27/13) at 11 a.m. for 15 minutes?", she indicated, "Yes."</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			

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 09/27/2013
---	--	--	--

NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
---	--

(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

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 09/27/2013
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042		
(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	
F000516 SS=E	<p>483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public.</p> <p>The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>The facility must safeguard clinical record information against loss, destruction, or unauthorized use.</p> <p>Based on observation, interview, and record review, the facility failed to protect resident information against unauthorized use and destruction, in that during 1 of 5 survey days, and 2 observations, an unlocked room contained multiple resident records which were also stored under sprinklers.</p> <p>Findings include:</p> <p>On 9/27/13 at 11:30 a.m., and 7:10 p.m., room #10 was observed unlocked. Inside the room, in the center and left side of the room, 28 cardboard storage boxes were observed setting on the floor or stacked 2 to 4 boxes high. Several file folders were observed laying on top of a table, and on top of some of</p>	F000516	F 516 Safe Guard Clinical records The policy and procedure for retention and storage of resident files was reviewed by the administrator. The social service Designee and department supervisors were in-serviced on safeguarding resident records. The administrator will be responsible to randomly monitor that resident medical records are safeguarded from unauthorized use and destruction. CQI will monitor residents medical records are safeguarded from unauthorized use and destruction, no less than quarterly.	10/26/2013	

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 09/27/2013
NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042		
(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 boxes. Resident names were written on the outside of the boxes and folders. The names included both current residents and residents that had been discharged.</p> <p>In the room, on the ceiling, were four sprinklers, and one sprinkler was directly over multiple boxes and folders.</p> <p>On 9/27/13 at 7:15 p.m., the Social Service Designee indicated the door was probably left unlocked when they were going in and out get resident information. She said the boxes were in the room, but the files will go back into the filing cabinet behind her office door.</p> <p>A policy and procedure for "Retention and Storage", with a last review date of 2/9/13, was provided by the Administrator on 9/27/13 at 7:45 p.m. The policy included, but was not limited to, "All clinical records shall be stored in areas that are free from damage and theft and are protected from loss, destruction and unauthorized use. Records shall be stored in a manner that maintains the confidentiality of information contained in the records. Active Records: Clinical records of residents currently in the facility are kept in a</p>				

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 09/27/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SILVER MEMORIES HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 6996 S US 421 VERSAILLES, IN 47042
---	--

(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>secure location which allows easy accessibility of resident information by authorized personnel. Discharged Records: Discharged records are stored in a secure location to prevent unauthorized access and in such a manner as to provide for prompt retrieval of resident information by authorized personnel. The records are retained after discharge for a minimum of one (1) year in the facility and five (5) years total; or, for a minor, until twenty-one (21) years of age and at least five (5) years from date of discharge."</p> <p>3.1-50(d)</p>			