| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155847 | A. BUILDING 00<br>B. WING | 09/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| SILVER MEMORIES HEALTH CARE | 6996 SOUTH US421<br>VERSAILLES, IN 47042 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: September 11, 12, 13, 14, and 15, 2023.<br><br>Facility number: 000483<br>Provider number: 155847<br>AIM number: 100273470<br><br>Census Bed Type:<br>SNF/NF: 29<br>Total: 29<br><br>Census Payor Type:<br>Medicaid: 28<br>Other: 1<br>Total: 29<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on September 19, 2023. | F 0000 | | |
| F 0689<br>SS=D<br>Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on observation, interview, and record | F 0689 | | 10/05/2023 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Sharon Woods | Administrator | 10/12/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | review, the facility failed to update a resident's fall interventions for 1 of 2 residents reviewed for accidents. (Resident 11)<br><br>Findings include:<br><br>During an observation on 09/13/23 at 9:06 A.M., Resident 11 was lying in her bed, awake with the TV on.<br><br>The clinical record was reviewed on 09/13/23 at 1:30 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 07/27/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, Huntington's disease, non-Alzheimer's disease, seizure disorder, anxiety, and depression. The resident had impairments on both sides of her lower extremities.<br><br>The Progress Notes, were reviewed and indicated the resident had multiple falls on the following dates and times:<br><br>- On 12/17/22 at 1:29 P.M., the resident was in the shower with staff. The staff were assisting the resident with a shower. The resident was resisting care and had raised herself up out of the chair lunged forward, landing on the floor in the prone position. She hit the right side of her forehead on the shower floor. The staff called for assistance. The resident had a small hematoma on the right side of her forehead. There were no other injuries noted. Neurological checks were initiated.<br><br>- On 12/19/22 at 2:05 P.M., the resident was sitting on the floor beside her bed. She indicated she was trying to get her call light that she thought was on the floor. The call light was on the bed. The resident denied hitting her head and neurological checks were initiated. There were no injuries | | F689<br>It is the practice of this facility to assure that resident needs are met and the care plan is updated to reflect resident's current needs.<br>Resident #11 has been reviewed to assure care plan accurately reflects post fall interventions.<br>Other residents that have the potential to be affected have been identified by:<br>All resident plans of care have been reviewed to assure that they accurately reflect the residents' current status related to post fall interventions.<br>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:<br>Licensed nurses have been in-serviced on Fall<br><br>prevention and updating the residents fall care plan with a new intervention for every fall. The Interdisciplinary team (IDT) has been in-serviced to assure that care plan updates and changes are made as they occur during clinical morning meeting.<br>The corrective action taken to monitor performance to assure compliance through quality assurance is:<br>A Performance Improvement Tool has been initiated that randomly reviews 5 residents related to care plans and revisions related to post fall interventions. The Director of | |

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| | noted.<br><br>- On 01/22/23 at 12:00 P.M., the resident was found in her bedroom, lying on the floor beside the wheelchair on a pile of blankets. The resident indicated she was trying to reach her call light. Her call light was attached to her clothing and was within reach. There were no injuries noted and neurological checks were initiated.<br><br>The resident's at risk for falls care plan with an initiated date of 06/09/21, included the followings interventions:<br><br>- Start date of 06/09/21, anticipate and meet the resident needs. Assure that the call light was within reach and encourage the use it for assistance as needed and provide a prompt response to all requests for assistance. Physical therapy, occupational therapy, and speech therapy evaluate and treat as ordered or as needed.<br><br>- Start date of 08/02/21, assist the resident repositioning as indicated.<br><br>- Start date of 09/27/21, educate the resident as indicated that is safer for her to sit in a chair with arms for proper positing.<br><br>- Start date of 10/05/21, educate the resident/family/caregivers about safety reminders and what to do if a fall occurred and encourage afternoon naps.<br><br>- Start date of 10/07/21, educate the resident to use her call light to ask for assistance prior to transfers from her chair at bedside.<br><br>- Start date 10/19/21, adjust tilt and space | | Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Monitoring will continue until no issues are noted or 100% compliance for 2 consecutive quarters. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tools.<br>The date the systemic changes will be completed:<br>October 5, 2023 | |

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| | wheelchair, broda chair, as indicated to position the resident to minimize risk of the resident coming out of the chair due to Huntington's movements.<br><br>- Start date of 10/20/21, assist the resident as indicated with eating if she was having increased Huntington's movements.<br><br>- Start date of 10/29/21, educate the resident as indicated on proper behaviors, assist the resident to lie down in bed as indicated for increased Huntington's movements.<br><br>- Start date of 11/05/21, continue to remind the resident to request assistance from staff. Offer positive reinforcement when she does request assistance. Encourage resident to use light to ask for assistance to get items out of reach.<br><br>- Start date of 11/12/21, the staff were to keep items within reach as needed.<br><br>- Start date of 12/05/21, remind the resident as indicated about safety precautions and praise her for being safe.<br><br>- Start date of 03/13/22, observe the resident as needed while in bed to ensure that she was in the center of the bed or towards the wall.<br><br>- Start date of 01/30/23, staff were to stand in front or beside the resident while on the commode.<br><br>- Start date of 05/28/23, place things of need on bed side table close to bed while in bed.<br><br>The clinical record lacked updated interventions after the resident's falls on 12/17/22, 12/19/22, and 01/22/23. | | | |

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| | During an interview on 09/13/23 at 2:51 P.M., LPN (Licensed Practical Nurse) 2 indicated the resident had Huntington's disease. The resident required the assistance of two physical staff. The resident falls were documented in risk assessments.<br><br>During an interview on 09/14/23 at 4:04 P.M., the DON (Director of Nursing) indicated new interventions would be initiated on the care plan and were updated after each fall.<br><br>During an interview on 09/15/23 at 9:36 A.M., the DON indicated the management team met every morning and would review falls. A progress note would be initiated after the fall and would determine an immediate intervention. The management team would review it and determine if it was an appropriate intervention or if it needed to be changed. There were no documented IDT (Interdisplinary Team) notes for the falls on 12/17/22, 12/19/22, or 01/22/23. There should have been updated interventions after the falls.<br><br>The current facility policy titled, "Falls", with a revised date of 2018 was provided by the DON on 09/15/23 at 12:35 P.M. The policy indicated, "...Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling..."<br><br>3.1-45(a)(2) | | | |
| F 0698<br>SS=D<br>Bldg. 00 | 483.25(l)<br>Dialysis<br>§483.25(l) Dialysis.<br>The facility must ensure that residents who require dialysis receive such services, | | | |

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| | consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>Based on observation, interview, and record review, the facility failed to monitor a dialysis access site for 1 of 1 resident reviewed for dialysis. (Resident 25)<br><br>Findings include:<br><br>During an observation on 09/14/23 at 2:54 P.M., Resident 25 was in his wheelchair.<br><br>A Quarterly MDS (Minimum Data Set) assessment, dated 08/12/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, end stage renal disease, anemia, heart failure, hypertension, diabetes, and dependence on renal dialysis.<br><br>The physician's order for the resident indicated a standard order to inspect the dialysis access site fistula on the left forearm for infection daily. Access the site for bruit and thrill, with a start date of 08/23/23.<br><br>The August and September 2023 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) lacked a physician's order or documentation related to bruit and thrill monitoring.<br><br>During an interview on 09/13/23 at 2:45 P.M., LPN (Licensed Practical Nurse) 2 indicated the resident went to dialysis three days a week. The resident had a fistula, and the bruit and thrill should be monitored every shift and documented in the EMAR. The nurse would have to check off that | F 0698 | F698<br>Resident #25 Physicians orders were reviewed and revised to ensure daily monitoring of the dialysis access site for thrill and bruit.<br>Other residents that have the potential to be affected have been identified by:<br>All residents with dialysis access have the potential to be affected by the alleged deficient practice.<br><br>No other residents identified.<br>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:<br>Licensed nurses have been in-serviced on monitoring dialysis site for thrill and bruit.<br>The corrective action taken to monitor performance to assure compliance through quality assurance is:<br>A Performance Improvement Tool has been initiated that randomly reviews 5 residents related to monitoring dialysis access site for thrill and bruit. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Monitoring will continue until no issues are noted or 100% compliance for 2 consecutive | 10/05/2023 |

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| | she assessed it. She thought the order was a standard order and it didn't show up on the EMAR.<br><br>During an interview on 09/13/23 at 2:56 P.M., the Administrator indicated the bruit and thrill monitoring should be documented on the EMAR.<br><br>The current facility policy titled, "Hemodialysis Access Care", with a revised date of September 2010, was provided by the Administrator on 09/14/23 at 9:00 A.M. The policy indicated, "...Check patency of the site at regular intervals. Palpate the site to feel the "thrill" or use a stethoscope to hear the "whoosh" or "bruit" of blood flow through the access"...<br><br>3.1-37(a) | | quarters. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tools.<br>The date the systemic changes will be completed:<br>October 5, 2023 | |
| F 0725<br>SS=E<br>Bldg. 00 | 483.35(a)(1)(2)<br>Sufficient Nursing Staff<br>§483.35(a) Sufficient Staff.<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: | | | |

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| | (i) Except when waived under paragraph (e) of this section, licensed nurses; and<br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br>Based on record review and interview, the facility failed to have sufficient nurse staffing for 24 hours hours a day. This deficient practice had the potential to affect 28 of 29 residents that resided in the facility.<br><br>Findings include:<br><br>The Labor Detail Reports were provided by the Administrator on 09/11/23 at 2:00 P.M. The reports indicated there was a licensed nurse, providing direct resident care, for less than 24 hours on the following dates and times:<br><br>- On 01/15/23 there were 23.75 licensed nurse hours in a 24 hour time.<br>- On 01/21/23 there were 23.50 licensed nurse hours in a 24 hour time.<br>- On 01/22/23 there were 23.75 licensed nurse hours in a 24 hour time.<br>- On 01/28/23 there were 23.75 licensed nurse hours in a 24 hour time.<br>- On 02/12/23 there were 23.25 licensed nurse hours in a 24 hour time,.<br>- On 03/03/23 there were 23.75 licensed nurse hours in a 24 hour time.<br>- On 03/24/23 there were 23.75 licensed nurse hours in a 24 hour time.<br>- On 03/26/23 there were 23.75 licensed nurse hours in a 24 hour time. | F 0725 | F725The corrective action taken for those residents found to be affected by the deficient practice include:<br>No residents were specifically identified.<br>Other residents that have the potential to be affected have been identified by:<br>All residents have the potential to be affected by the alleged deficient practice.<br>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:<br>The BOM/HR and Director of Nursing has been in-serviced related to assuring that the facility has sufficient licensed nurse coverage 24 hours a day or they must notify ADMIN. See below for monitoring.<br>The corrective action taken to monitor performance to assure compliance through quality assurance is:<br>A Performance Improvement Tool has been initiated that randomly reviews required nursing schedule | 10/05/2023 |

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| | During an interview on 09/11/23 at 2:45 P.M., the Administrator indicated the nurses didn't leave the building for lunch. A thirty minute lunch break was automatically deducted and taken out of their time. She was unsure at the time why the PBJ (Staffing Data Report) showed that they had less than 24 hours nurse coverage. The labor detail reports for nursing was where the information for the PBJ was pulled from.<br><br>During an interview on 09/14/23 at 2:12 P.M., the Administrator indicated she was unaware that the 30 minute lunch break wasn't included in the nursing hours.<br><br>The current facility policy titled "Staffing" with a revised date of October 2017, was provided by the Administrator on 09/14/23 at 3:00 P.M. The policy indicated, "...Licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services..."<br><br>3.1-17(b) | | information to assure proper licensed nurse coverage. The Director of Nursing, Business Office Manager, or designee will complete this tool weekly x3, monthly x3, and quarterly x3. Monitoring will continue until no issues are noted or 100% compliance for 2 consecutive quarters. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.<br>The date the systemic changes will be completed:<br>October 5, 2023 | |
| F 0912 SS=D Bldg. 00 | 483.90(e)(1)(ii)<br>Bedrooms Measure at Least 80 Sq Ft/Resident<br>§483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms;<br>Based on observation, record review, and interview, the facility failed to provide at least 80 sq ft per resident for 2 of 11 resident rooms. (Rooms 1 and 3)<br><br>1. During an observation of Room 1 on 09/11/23 at 11:15 A.M., each of the four residents in this room had adequate space to move about the room and store their belongings. | F 0912 | **F 912 It is the practice of this facility to assure that all residents' needs are met.**<br>**The correction action taken for those residents found to be affected by the deficient practice include**:<br>Rooms 1 and 3 are identified. The facility has submitted a waiver | 10/05/2023 |

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| | During an observation and interview on 09/15/23 at 1:08 P.M., Room 1 (a licensed Skilled Nursing Facility/Nursing Facility [SNF/NF]) was measured at 316 sq ft (square feet). This room had 79 sq ft for each of the four residents who resided in the room. The room size was verified by the Maintenance Director.<br><br>2. During an observation of Room 3 on 09/11/23 at 11:20 A.M., each of the three residents in this room had adequate space to move about the room and store their belongings.<br><br>During an observation on 09/15/23 at 1:11 P.M., Room 3 (SNF/NF room) was measured at 218 sq ft. This room had 72 sq ft for each of the three residents who resided in the room. The room size was verified by the Maintenance Director.<br><br>During an interview on 09/15/23 at 1:14 P.M., the Administrator indicated she would like to continue with the room waivers.<br><br>3.1-19(l)(2)(A)<br>3.1-19(l)(3)<br>3.1-19(l)(8) | | request related to the square footage requirements.<br>**Other residents that have the potential to be affected have been identified by:**<br>No Other residents or resident's rooms are affected.<br>**The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:**<br>The square footage requirements in no way affects the care that is provided to the residents in rooms 1 and 3. These residents receive the highest quality of services. A waiver has been submitted related to the square footage requirements which have been granted annually. Residents in room 1 and 3 will be interviewed, no less than quarterly by the social service designee to ensure room environment is not effecting their care and services needed. The Social Service Designee will report any concerns verbalized immediately to the administrator for correction. Quality Assurance committee will review resident interview results during their scheduled meeting for no 3 quarters or until no issues are noted or 100% compliance for 2 consecutive quarters. | |