STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155847	A. BUILDING 00 B. WING	10/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: October 17, 18, 19, 20, and 21, 2022. Facility number: 000483 Provider number: 155847 AIM number: 100273470 Census Bed Type: SNF/NF: 29 Total: 29 Census Payor Type: Medicare: 3 Medicaid: 24 Other: 2 Total: 29 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 31, 2022.	F 0000	**Silver Memories POC 2022** **By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective November 11, 2022, to the annual licensure survey completed on October 21, 2022. We respectfully request a paper review and will provide any additional information requested.**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record	F 0684	**F684**	11/11/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sharon	Woods	11/10/2022

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 follow manufacturer's guidelines related to insulin pen usage for 1 of 12 residents reviewed for quality of care. (Resident 12) Findings include: Medication administration was observed on 10/20/22 at 11:54 A.M., with LPN (Licensed Practical Nurse) 3. The observation indicated the following: - LPN 3 removed Resident 12's insulin pen from the treatment cart, removed the pen cap, applied a new needle, and primed the pen with two units of insulin leaving the cap on the needle. She was unable to visibly see the tip of the needle while holding the pen horizontally. She did not clean the end of the pen before applying the needle to administer 15 units of Novolog to the resident. During an interview on 10/20/22 at 12:14 P.M., LPN 3 indicated she did not know why she had not cleaned the end of the insulin pen before applying the needle. She would have cleaned the top of a vial of insulin and she would of held the insulin pen upright to prime it. During an interview on 10/21/22 at 1:21 P.M., the DON (Director of Nursing) indicated no residents had recently had any acute concerns related to blood glucose levels. The current "Novolog Package Insert", with a revised date of 09/11/2015, was provided by the DON on 10/21/22 at 1:14 P.M. The insert indicated, "...Before each injection...Wipe the Rubber Seal with an alcohol swab. To avoid injecting air and to ensure proper dosing...Turn the dose selector to select 2 units. Hold your Pen with the needle		**It is the practice of this facility to assure that insulin pens are cleansed and primed per manufacturer's guidelines.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** The facility will ensure, resident # 12 insulin pen is cleansed and primed prior to administration in accordance with the manufacturer's guidelines. ***Other residents that have the potential to be affected have been identified by:*** All diabetic residents that are receiving insulin using an insulin pens have been reviewed to ensure the insulin pen is used in accordance with manufacturer's guidelines. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Nurses have been in-serviced on cleaning and priming insulin pens prior to administration in accordance with the manufacturer's guidelines including return demonstration. Please see below for monitoring. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly	

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	pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the bottom all the way in...A drop of insulin should appear at the needle tip..." The current "Insulin Pen" policy, dated August 5, 2019, was provided by the DON on 10/21/22 at 2:26 P.M. The policy indicated, "...Remove the cap from the pen and wipe the attachment area with an alcohol swab...Prime the pen by removing air from the needle by turning the dial to two units...Hold the pen and point the needle up. Gently tap the pen to move the air bubble up to the top of the pen. Press the inject button. You should see insulin appear at the tip of the needle /pen...." 3.1-47(a)(1)		reviews 5 resident's administration of insulin via insulin pen will be observed to assure that the insulin pen is cleansed and primed appropriately in accordance with manufacturer's guidelines. The DON, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. 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.The Quality Assurance Committee will review the Performance improvement Tool as indicated above and will increase to weekly monitoring if <90% of residents reviewed show compliance. The Quality Assurance Committee will continue to review the Performance improvement Tool until auditing tools are showing 100% compliance at which time the Quality Assurance Committee may decrease the monitoring increments. ***The date the systemic changes will be completed:*** November 11, 2022	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience			

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	reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview, and record review, the facility failed to ensure a resident properly utilized a brace device for 1 of 12 residents reviewed for range of motion. (Resident 128) Findings include: On 10/19/22 at 10:04 A.M., Resident 128 was observed in his room in bed. A brace device for the resident's foot was observed on his chair next to his bed. On 10/20/22 at 9:20 A.M., the resident was observed in his room in bed. The resident's foot brace was in the chair next to the resident's bed. On 10/20/22 at 11:44 A.M., the resident was observed in his room sitting up in the chair next to his bed. The resident was wearing a brace on his left foot. On 10/20/22 at 2:42 P.M., the resident was observed in his room in bed. The resident's foot	F 0688	**F688** **It is the practice of this facility to assure that residents receive the services in accordance with the plan of care to minimize the risk of a resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident #128 is wearing the device in accordance with the plan of care. ***Other residents that have the potential to be affected have been identified by:***	11/11/2022

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	brace was on his chair next to the resident's bed. During an interview on 10/20/22 at 2:52 P.M., CNA (Certified Nurse Aide) 4 indicated the resident wore a brace on his left foot for foot drop. The therapy department would put the brace on the resident when they got him out of bed in the morning or nursing staff would put it on if they got him out of the bed. Sometimes he wore the brace when he was in bed for a little while. The resident's clinical record was reviewed on 10/20/22 at 2:00 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 09/14/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, stroke, neurogenic bladder, hemiplegia, and depression. The resident required extensive staff assistance with most ADLs (Activities of Daily Living). The resident's range of motion of their upper and lower extremities was impaired on one side and the resident utilized a wheelchair. The resident's current physician's orders included an open ended order, with a start date of 09/02/22, indicated the resident's ankle resting splint/brace for the left foot was to be worn while the resident was in bed for foot drop and contracture management. During an interview on 10/21/22 at 9:03 A.M., Therapy Director 2 indicated the resident's left foot was contracted. His foot was in a state of plantar flexion (the top of the foot pointed away from the leg). The brace brought the foot back to a neutral position. In the mornings, the therapy department would usually get the resident out of bed and into his chair and put the brace in place. The resident brought the brace with him when he was admitted to the facility. He wasn't wearing the		All residents have been reviewed to assure devices are utilized according to their individual needs as indicated in their individualized plan of care.. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All nursing staff have been in-serviced related to ensuring that brace devices are in place in accordance with resident's physician orders and resident's individual plan of care. See below for monitoring systems. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that will be utilized to randomly observe up to 5 residents related to comparing devices noted in their individualized care plan to assure brace devices are in place as physician ordered and individual care plans indicate. The Director of Nursing, or designee, will complete this tool weekly x3, then monthly x3, then quarterly x3. Any areas identified via the audit or daily review will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed	

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	brace at first. The therapist came and evaluated the resident and wrote the order for the resident to wear the brace while he was in bed in September 2022. They wanted the resident to wear the brace as much as he could. It was appropriate that the resident wear the brace when he was up in the chair, but he should be wearing it when he was in bed. She thought the resident asked staff to remove the brace when he was in bed. During an interview on 10/21/22 at 9:58 A.M., the DON (Director of Nursing) indicated if a resident refused medication or a treatment, nursing staff would document the refusal in the resident's clinical record, and they would notify the resident's physician. The resident's clinical record lacked documentation the resident refused to wear the brace when in bed. During an interview on 10/21/22 at 9:53 A.M., the resident indicated he didn't mind wearing the brace, and he didn't mind wearing the brace when he was in bed. During an interview on 10/21/22 at 2:17 P.M., the Administrator indicated it was standard nursing practice to follow physician's orders, including following physician's orders for splint or brace device usage. 3.1-42(a)(2)		based on the outcome of the tools.The Quality Assurance Committee will review the Performance improvement Tool as indicated above and will increase to weekly monitoring if <90% of residents reviewed show compliance. The Quality Assurance Committee will continue to review the Performance improvement Tool until auditing tools are showing 100% compliance at which time the Quality Assurance Committee may decrease the monitoring increments. ***The date the systemic changes will be completed:*** November 11, 2022	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary			

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	drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on observation, interview, and record review, the facility failed to follow a physician's order related to a blood pressure medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 19) Findings include: During an observation and interview on 10/20/22 at 11:48 A.M., QMA (Qualified Medication Aide) 5 prepared Resident 19's medications by placing metformin (a blood sugar medications) and risperidone (an antipsychotic medication) into a medication cup and the resident's hydralazine (blood pressure medication) into a separate medication cup. The medications were taken to the resident's room. The QMA obtained the resident's blood pressure, and it was 148/56. The QMA indicated the resident's blood pressure medication would not be administered due to the	F 0757	**F757** **It is the practice of this facility to assure resident's drug regimen are free from unnecessary drugs.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident #19 physician's orders and B/P recordings have been reviewed. Resident #19 is receiving her medications as indicated and observing medication parameters. ***Other residents that have the potential to be affected have been identified by:*** All residents with medication administration parameters have	11/11/2022

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	bottom number being less than 60. The resident had hold parameters on the blood pressure medication to hold the medication if the top number was less than 110 and the bottom number was less than 60. The other medications were administered. The clinical record for Resident 19 was reviewed on 10/18/22 at 1:35 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 08/22/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, hypertension, renal insufficiency, diabetes, aphasia, anxiety, depression, and psychotic disorder. A physician's order, dated 03/22/22 through 10/20/22, indicated the nursing staff were to give the resident hydralazine 10 mg (milligrams), give 2 tablets, by mouth, three times a day for hypertension. The medication was to be held for a blood pressure less than or equal to 110/60 and/or a pulse less than or equal to 60. The August, September, and October 2022 EMAR (Electronic Medication Administration Record) indicated the resident had received the medication on the following dates and times when the blood pressures were out of the parameters: - 08/03/22 at 8:00 A.M., the bottom number was 60, - 08/03/22 at 1:00 P.M., the bottom number was 60, - 08/11/22 at 8:00 A.M., the bottom number was 60, - 08/11/22 at 1:00 P.M., the bottom number was 60, - 08/30/22 at 8:00 A.M., the bottom number was 60, - 08/30/22 at 1:00 P.M., the bottom number was 60, - 09/01/22 at 8:00 A.M., the top number was 104, - 09/01/22 at 1:00 P.M., the top number was 104, - 09/01/22 at 8:00 P.M., the top number was 110, - 09/03/22 at 1:00 P.M., the top number was 110,		been reviewed for accuracy of drug administration according to parameters ordered. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** An in-service has been conducted for nurses related to assessment of residents in accordance with physician ordered medication administration parameters, including obtaining and review of blood pressures for residents with an order to obtain blood pressure prior to administration withhold parameters. See means of monitoring below. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that will be utilized to randomly review 5 residents (if applicable) related to parameter assessment including blood pressure to assure that medications are not unnecessarily administered. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any areas identified via the audit will be immediately corrected.The Quality Assurance Committee will review the Performance improvement Tool as indicated above and will increase to weekly monitoring if	

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	- 09/29/22 at 8:00 A.M., the top number was 106, - 10/03/22 at 12:00 P.M., no blood pressure was documented, - 10/04/22 at 8:00 A.M. and 12:00 P.M., no blood pressure was documented, - 10/05/22 at 8:00 A.M., no blood pressure was documented, and - 10/15/22 at 8:00 A.M., the top number was 110. During an interview on 10/21/22 at 9:46 A.M., RN 6 had reviewed Resident 19's hydralazine order and indicated the medication should not have been administered if the top number was less than or equal to 110 and the bottom number was less than or equal to 60. It was held when either of the numbers were out of range. The current facility policy, titled "Administering Medications" with a revised date of December 2012, was provided by the DON (Director of Nursing) on 10/21/22 at 2:10 P.M. The policy indicated, "...Medications must be administered in accordance with the orders, including required time frame..." 3.1-48(a)(3)		<90% of residents reviewed show compliance. The Quality Assurance Committee will continue to review the Performance improvement Tool until auditing tools are showing 100% compliance at which time the Quality Assurance Committee may decrease the monitoring increments. ***The date the systemic changes will be completed:*** November 11, 2022	
F 0912 SS=D Bldg. 00	483.90(e)(1)(ii) Bedrooms Measure at Least 80 Sq Ft/Resident §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; Based on observation, interview, and record review, the facility failed to provide at least 80 square feet(sq ft) per resident for 2 of 11 resident bedrooms in the facility. (Rooms 1 and 3) Findings include:	F 0912	**F 912 It is the practice of this facility to assure that all residents' needs are met.** **The correction action taken for those residents found to be affected by the deficient**	11/11/2022

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	Review of the facility documentation of room size certification, provided by the Administrator, on 10/21/22 at 2:15 P.M., indicated the following room sizes, as observed on facility tour, provided less than 80 square feet per resident: 1. Room 1, SNF/NF (Skilled Nursing Facility/Nursing Facility), was 318.5 sq ft, had the capacity for 4 beds, and equaled 79.6 sq ft per resident. During an observation of Room 1 on 10/21/22 at 10:28 A.M., each resident had adequate space to move about the room and store their belongings. The room measurements were confirmed. 2. Room 3, SNF/NF, was 217.4 sq ft, had the capacity for 3 beds, and equaled 72.5 sq ft per resident. During an observation of Room 3 on 10/21/22 at 10:31 A.M., each resident had adequate space to move about the room and store their belongings. The room measurements were confirmed. These room sizes were verified by the Maintenance Director on 10/21/22 at 2:21 P.M. During an interview on 10/21/22 at 1:29 P.M., the Administrator indicated she would like to continue with the room waiver. 3.1-19(l)(2)(A) 3.1-19(l)(3) 3.1-19(l)(8)		**practice include**: Rooms 1 and 3 are identified. The facility has submitted a waiver request related to the square footage requirements. **Other residents that have the potential to be affected have been identified by:** No Other residents or resident's rooms are affected. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:** 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.	

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			F 912 It is the practice of this facility to assure that all residents' needs are met. **The correction action taken for those residents found to be affected by the deficient practice include**: Rooms 1 and 3 are identified. The facility has submitted a waiver request related to the square footage requirements. **Other residents that have the potential to be affected have been identified by:** No Other residents or resident's rooms are affected. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:** 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	

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			waiver has been submitted related to the square footage requirements which have been granted annually.	