

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155847	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER Silver Memories Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 6996 South Us421 Versailles, IN 47042	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on interview and record review, the facility failed to provide appropriate assistance with a mechanical lift device to ensure safe transfers for 1 of 3 residents reviewed for transfer/mobility devices. (Resident B) Findings include: A Quarterly Minimum Data Set (MDS) assessment, dated 9/1/25, indicated Resident B was severely cognitively impaired. The resident's diagnoses included, but were not limited to, non-traumatic brain dysfunction, Alzheimer's disease, and hypertension. The Resident was dependent on staff assistance for all mobility. During an interview, on 9/18/25 at 9:57 A.M., the Administrator indicated Certified Nursing Assistant (CNA) 2 used the full body mechanical lift on Resident B without any additional staff assistance on 8/12/25. The mechanical lifts should always be operated with two staff present, and staff were available to assist if the CNA would have requested for assistance. CNA 2 was discharged from service due to using a mechanical lift improperly. During an interview, on 9/18/25 at 10:42 A.M., CNA 2 indicated that on 8/12/25 she had put Resident B down for bed sometime between 6:00 P.M. to 8:00 P.M. She used the full body mechanical lift to transfer the resident into the bed with no other staff present. During transferring the resident to bed she was removing the sling from the mechanical lift; one of the wheels to the mechanical lift had gotten caught on a cord for the resident's bed causing her to pull the lift away firmly. When she pulled the lift firmly out from overtop of the resident, the top bar of the lift where the lift pad had been hooked began to spin around. She stopped the rotation of the lift bar after she noticed it spinning. Later on her shift around 4:00 A.M., she had used the mechanical lift, a second time by herself, and got the resident up from bed to her wheelchair. She then wheeled the resident out of her room. During an interview, on 9/18/25 at 10:57 A.M., Registered Nurse (RN) 3 indicated she was working with CNA 2 on 8/12/25. She observed CNA 2 bring Resident B out of her room and into the dining room around 4:00 A.M. At that time, she noticed Resident B had purple bruising around her left eye, and a small cut over the bridge of her nose with a small spot of dried blood. When she questioned CNA 2 about the resident's injury, the CNA denied knowing when the injury occurred. The current facility policy, titled Lifting Machine, using a Mechanical, with a revision date July 2017, was provided by the Administrator on 9/18/25 at 2:50 P.M. The policy indicated, .At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift .This deficiency was corrected on 8/19/25, after the facility assessed all residents requiring mechanical lifts, provided education to staff related to proper procedure for transfers, all staff returned proper demonstration of transfers, and ongoing monitoring audit in place for safe transfers. This citation relates to Intake 2588897.3.1-45(a)(1)3.1-45(a)(2)</p>

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.

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