

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E657	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2014
--	---	--	---

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
--------------------	--	---------------	---	----------------------

K010000	<p>A Life Safety Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/25/14</p> <p>Facility Number: 000483 Provider Number: 15E657 AIM Number: 100273470</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Silver Memories Health Care was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This two story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detection in all resident sleeping rooms. The facility</p>	K010000	Request for an extension for completion date of January 25, 2015	
---------	---	---------	--	--

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 01 B. WING _____		X3) DATE SURVEY COMPLETED 11/25/2014	
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			
K010025 SS=E	<p>has a capacity of 29 and had a census of 19 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinkled and all areas providing facility services were sprinkled.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observations and interview, the facility failed to ensure the smoke barriers in 1 of 1 ceiling and 3 of 27 room walls were constructed to provide at least a one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable wire to be protected so the space between the penetrating item and</p>	K010025	<p>K 025 NFPA 101 Life Safety Code Standards</p> <p>1. The soiled linen room wall water line access panel was replaced on the wall to ensure at least a half hour resistance rating in accordance to 8.3.</p> <p>2. The gaps in the biohazard room will be filled with fire rated caulking to ensure at least a half</p>	01/25/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E657		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 11/25/2014	
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 smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice affects 12 residents who use the main dining room, located adjacent to the soiled linen room, biohazard room and director of nursing office.</p> <p>Findings include:</p> <p>Based on observations with the administrator during a tour of the facility on 11/25/14 from 8:05 a.m. to 12:50 p.m., the following locations had ceiling and wall penetrations not firestopped or were firestopped with non rated foam;</p> <ol style="list-style-type: none"> 1. The soiled linen room wall under the sink had a two foot by one foot square area of drywall missing with wood studs exposed. 2. The biohazard room south wall had a two inch gap around a duct penetration not firestopped and four, two inch circular gaps in the drywall not firestopped. 3. The corridor ceiling by room 1 and room 2 had a one half inch gap where the wall and ceiling met along a twenty foot corridor with no firestopping used to seal the gap. 4. The director of nursing office south 		<p>hour resistance rating in accordance to 8.3.</p> <ol style="list-style-type: none"> 3. The corridor ceiling gap by room 1 and room 2 will be filled with fire caulk to ensure at least a half hour resistance rating in accordance to 8.3. 4. The yellow expandable foam will be removed from the director of nursing office and replaced with fire rated caulk to ensure at least a half hour resistance rating in accordance to 8.3. <p>Environmental supervisor will be responsible to assess all rooms for gaps which would prevent at least a half hour resistance rating in accordance to 8.3, no less than weekly. CQI will monitor weekly floor tours, no less than quarterly.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E657	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2014
--	---	--	---

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
K010029 SS=E	<p>wall had a duct penetration filled with yellow expandable foam. Based on an interview with the administrator on 11/25/14 at 11:10 a.m., the expandable foam is not fire rated. The soiled linen room wall missing drywall, the biohazard room wall not firestopped, the corridor ceiling by room 1 and 2 not firestopped and the use of non rated expandable foam was acknowledged by the administrator at the exit conference on 11/25/14 at 1:30 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 3 hazardous area, such as a combustible storage room over 50 square feet, was provided with a self closing device which would cause the door to</p>	K010029	<p>K 029 NFPA 101 Life Safety Code Standards</p> <p>A self-closing device will be applied to the kitchen storage area door. The environmental supervisor will ensure the self-closure device is working appropriately, no less than</p>	01/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E657		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 11/25/2014	
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			
K010046 SS=E	<p>automatically close and latch into the door frame. This deficient practice affects 12 residents who use the main dining room, located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 11/25/14 at 10:40 a.m. with the administrator, the kitchen storage room, which measured one hundred sixty square feet and had six shelves of food stored in combustible paper and cardboard boxes, lacked a self closing device on the door. This was verified by the administrator at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 15 battery backup lights functioned to provide at least 1 1/2 hour duration of emergency lighting. This deficient practice could affect 4 residents who reside in room 1 and room 2.</p> <p>Findings include:</p>	K010046	<p>monthly during all fire drills. CQI will monitor all self-closure devices are working functionally, no less than quarterly.</p> <p>K 046 NFPA 101 Life Safety Code The battery in the emergency light located in the Administration Hall Corridor will be replaced. The environmental supervisor will be responsible to monitor battery backup of all emergency lighting, no less than monthly during fire drills. Koorsen Fire and Security will continue to check emergency lights are functioning, no less than</p>	01/25/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E657	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2014
--	---	--	---

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
K010052 SS=F	<p>Based on observation and testing of the battery backup light in the Administration Hall corridor with the administrator on 11/25/14 at 11:10 a.m., the test button was depressed on two separate tests and the battery backup light failed to light. This was verified by the administrator at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review and interview, the facility failed to ensure 2 of 17 fire alarm system components were maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. Table 7-3.2 shall apply. Table 7-3.2 "Testing Frequencies" requires alarm initiating devices, alarm notification appliances, batteries, and initiating devices to be</p>	K010052	<p>annually. CQI committee will monitor all emergency backup lighting is tested, no less than quarterly.</p> <p>On 11/26/2014, Koorsen Fire and Security came into the facility and repaired the wiring to the panel and ensured the low air and the post indicator valve was in compliance. Koorsen's Fire and Security will be responsible to monitor compliance of all fire alarm system components during the semiannual Sprinkler test. The Environmental Supervisor will be responsible to review all Koorsen's Fire and Security inspection reports following their inspection. CQI committee will review all fire alarm inspection reports, no less than quarterly.</p>	01/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E657		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 11/25/2014	
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			
K010062	<p>tested at least annually. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the facility's Koorsen Fire Alarm System Inspection and Testing Report on 11/25/14 at 12:30 p.m. with the administrator, the annual report dated 04/03/14 indicated the low air pressure switch on the sprinkler riser and the post indicator valve alarm switch were both tested and failed to cause an alarm response at the fire alarm panel. Based on an interview with the administrator on 11/25/14 at 12:40 p.m., when asked if the low air pressure switch and post indicator valve alarm switch were repaired or replaced, the administrator indicated there was no knowledge of the two switches being repaired or replaced or any report from Koorsen to indicate the work had been performed. The lack of low air pressure switch and post indicator valve switch causing an alarm response at the fire alarm system panel was verified by the administrator at the time of interview.</p> <p>3.1-19(b)</p> <p>NFPA 101</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E657		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 11/25/2014	
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			
SS=E	<p>LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 requires sprinkler piping or hangers shall not be used to support nonsystem components. This deficient practice could affect any residents using the Administration Hall near the central supply room.</p> <p>Findings include:</p> <p>Based on observation on 11/25/14 at 12:10 p.m. with the administrator, room 8 bathroom had a two inch sprinkler pipe ran along the east wall with zip strip ties used to tie down cable television wiring along the ten foot length of sprinkler pipe. This was verified by the administrator at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 138 sprinkler heads in the facility were maintained. This deficient practice could</p>	K010062	<p>K O62 NFPA 101 Life Safety Code Standard</p> <p>1. Direct TV is scheduled to come into the facility no later than February 1, 2015 to remove the cable they connected to the 2 in sprinkler pipe and rewire the cable line.</p> <p>2.2 escutcheons has been order to place in the 2 sprinkler heads located in the dining room. Environmental Supervisor will be responsible to ensure repairs are conducted and to ensure sprinkler pipe or sprinkler pipe hangers are not used to support non-system components during their monthly facility inspection. CQI Committee will monitor sprinkler pipe are not used to support non-system components and escutcheons are in place, no less than quarterly.</p>	01/25/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E657	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2014
--	---	--	---

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
K010064 SS=F	<p>affect 12 residents who use the main dining room.</p> <p>Findings include:</p> <p>Based on observation on 11/25/14 at 1:15 p.m. with the administrator, the two sprinklers near the main dining room exit door lacked escutcheons and were not flush to the ceiling leaving a one inch gap into the attic space above. This was verified by the administrator at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure 7 of 10 portable fire extinguishers were installed correctly. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be not more than three and one half feet (42 inches) above the floor. This deficient practice could affect all residents in the</p>	K010064	<p>K 064 Life Safety Code Standards All the facility fire extinguishers will be lowered to ensure the top of the fire extinguishers weighing 40 pounds or less are no higher than 60 inches from the floor and the tops of the fire extinguishers weighing more than 40 pounds are no higher than 42 inches from the floor. The environmental supervisor will be responsible to ensure fire extinguishers remain in correct position during their monthly facility review. CQI Committee will be responsible to ensure fire</p>	01/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E657		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 11/25/2014	
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			
K010066 SS=E	<p>facility.</p> <p>Findings include:</p> <p>Based on observations on 11/25/14 during a tour of the facility with the administrator from 8:05 a.m. to 12:30 p.m., the fire extinguisher at the nurses' station, the two kitchen fire extinguishers, the fire extinguisher in the corridor by the director of nursing office, the fire extinguisher next to the smoke barrier door set, the fire extinguisher in the corridor by laundry, and the fire extinguisher in the corridor by room 6 were mounted on the walls and measured between sixty six inches and seventy two inches from the top of the extinguishers to the floor. This was verified by the administrator at the time of observations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p>		extinguishers remain in correct position, no less than quarterly.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E657	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 11/25/2014
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	
K010074	<p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation, record review, and interview, the facility failed to ensure 1 of 1 area where smoking was permitted used the metal self closing containers for discarded smoking material. This deficient practice could affect 11 residents who smoke if a fire occurred at the outside front smoking location.</p> <p>Findings include: Based on observation at on 11/25/14 at 8:45 a.m. with the administrator, the outside front smoking location had thirty discarded cigarette butts on the ground surface. Furthermore, the smoking location lacked a metal container with self closing lid for discarded smoking material. This was verified by the administrator at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101</p>	K010066	<p>K 066 Life Safety Code Standards Residents were reminded of the facility smoking policy which includes extinguishing cigarettes in cigarette butt containers and not throwing cigarette butts on the ground. The facility has ordered a galvanized steel cigarette butt receptacle to place in the outside smoking area. All staff will be responsible to ensure residents follow the facility smoking policy and ensure cigarette butts are extinguished in provided containers and not thrown on the ground. The environmental supervisor or delegate will be responsible to ensure the outside area is free from cigarette butts on the ground during facility review tours. CQI committee members will be responsible to ensure smoking areas are free of cigarette butts on the ground and proper cigarette butt containers are available and maintained in a safe manner.</p>	01/25/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E657	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2014
--	---	--	---

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
SS=E	<p>LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure window curtains in 6 of 11 resident rooms were flame retardant. This deficient practice could affect 12 resident who reside in rooms 4, 5, 6, 7, 9, and 11.</p> <p>Findings include:</p> <p>Based on observations with the administrator during the tour of the facility on 11/25/14 from 8:05 a.m. to 12:50 p.m., room 4 three sets of cubicle curtains, room 5 two sets of cubicle curtains, room 6 set of cubicle curtains, room 7 set of cubicle curtains, room 9 two sets of cubicle curtains, and room 11 two sets of cubicle curtains lacked</p>	K010074	<p>K 074 101 Life Safety Code Standards</p> <p>The cubicle curtains in room 4, 5, 6, 7, 9 and 11 arescheduled to be treated with a flame retardant substance, no later thanFebruary 1, 2015 and then treated there after according to manufacturerecommendations, until replaced with cubical curtains with flame retardantlabels. The environmental supervisor will be responsible to ensure a scheduleis developed to treat and retreat the cubical curtains to ensure flameretardant substance is applied as directed by manufacture. CQI will beresponsible to review flame retardant treatment schedules and cubicle curtainsare replaced with cubicle curtains which are labeled</p>	01/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E657	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 11/25/2014
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>attached documentation that they were inherently flame retardant. Based on interview with the administrator on 11/25/14 at 10:20 a.m., room 4, 5, 6, 7, 9 and 11 have the old style cubicle curtains and they were washed so many times the fire rated labels have torn off.</p> <p>Furthermore, the administrator indicated there was no documentation available for review to indicated room 4, 5, 6, 7, 9 and 11 cubicle curtains were inherently flame retardant. The lack of documentation to indicated room 4, 5, 6, 7, 9 and 11 cubicle curtains were inherently flame retardant was verified by the administrator at the time of interview.</p> <p>3.1-19(b)</p>		flame retardant.		