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	11/26/2024

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: November 21, 22, 25, and 26, 2024. Facility number: 000483 Provider number: 155847 AIM number: 100273470 Census Bed Type: SNF/NF: 29 Total: 29 Census Payor Type: Medicaid: 29 Total: 29 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 1, 2024.	F 0000	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Silver Memories agrees with the allegations and citations listed. Silver Memories maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review for this plan of correction.	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to follow the manufacturer's guidelines related to the dishwasher temperatures and chemical sanitation for 1 of 2 kitchen observations and failed to maintain the resident snack refrigerator in a sanitary manner related to the storage of undated and unlabeled food and non-food items for 1 of 1 snack refrigerator observed. This deficient practice had the potential to affect 29 of 29	F 0812	***F 812 Food Procurement, Store/Prepare/Serve-Sanitary*** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The dish machine was placed out of service until chemical level reached between	12/20/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sharon F Woods	Administrator	12/13/2024

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	residents who received food from the kitchen or snack refrigerators. Findings include: During the initial kitchen tour on 11/21/24 at 10:48 A.M., with Human Resources (HR) 1, the following was observed: - The thermometer on the dishwasher registered 90 degrees Fahrenheit during the rinse cycle. The sticker on the machine indicated it was supposed to be 120 degrees Fahrenheit. There was no steam rising off of the dishwasher. - A chemical test of the dishwasher solution was conducted with HR 1 and the result was 10 Parts Per Million (PPM). HR 1 indicated it was supposed to be between 50 and 100 PPM. The residents' snack refrigerator, located in the kitchen, contained the following: - A cow print lunch bag with no resident's name or date, - A small gray lunch bag with no resident's name or date that contained a package of pistachios, and - an open box of ice cream sandwiches with no resident's name or date. HR 1 indicated an employee had donated the ice cream sandwiches. HR 1 and the other kitchen staff indicated they did not know to whom the lunch bags belonged to, and HR 1 removed them from the refrigerator. Dietary Aide (DA) 2 indicated they did not monitor the dishwasher temperatures, just the		50PPM. 3 compartment sink was utilized with chlorine testing being within recommended levels. The Maintenance Director replaced low level sanitizing liquid bottle with a full bottle. Primed the machine to fill the sanitizer supply line. The Dish Machine chemical test was conducted with results of 50 P.P.M. noted. Clean Slate Chemical provider/Servicing company was contacted to evaluate machine. Scheduled to come in the week of December 15th, 2024. Cow print and gray lunch bag and ice cream sandwiches were immediately removed from the resident's refrigerator. A chemical level sheet was started immediately while looking for previous chemical level sheets. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents with food/fluid items in the refrigerator have the potential to be affected. The Dietary Manager or her designee will complete an observation of the resident's refrigerator and record on an observation tool log at the beginning of their shift. Any findings will be corrected immediately. **What measures will be put into**	

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	chemical levels. On 11/21/24 at 11:04 A.M., the dishwasher was re-checked and the thermometer on the dishwasher only registered 98 degrees Fahrenheit. HR 1 indicated they would be using the three-sink sanitation system for dishwashing until the dishwasher was fixed. The Administrator was standing at the kitchen door at the time of the second running of the dishwasher and indicated the dishwasher usually had steam coming off of it. No steam was coming off of the dishwasher at the time. During an interview on 11/21/24 at 11:55 A.M., HR 1 indicated all residents in the facility received food from the kitchen. During an interview on 11/25/24 at 1:13 P.M., DA 2 indicated the residents' snack refrigerator was used for overflow of facility meal service items. During an interview on 11/26/24 at 2:07 P.M., the Dietary Manager indicated they tested the chemical level of the dishwasher everyday but did not know where the paper was, they documented the information on, it was not in the kitchen binder. An "Out of Order" sign remained on the dishwasher for the remaining time of the survey. The dishwasher Operating Manual was provided by the Maintenance Director on 11/26/24 at 1:28 P.M. and included, but was not limited to, the following requirements: - Ensure water temperatures match those listed on machine data plate,		**place or what systemic changes will be made to ensure that the deficient practice does not recur?** All dietary staff were educated on the correct operation of the dish machine, monitoring dish machine temperature and sanitizing requirement, and observation of all items in the dietary refrigerators and freezers. Clean Slate Chemical provider/Servicing company was contacted to evaluate machine. Scheduled to come in the week of December 15th, 2024. The Maintenance Director replaced the heating elements in the hot water heater. All staff were educated on their food items cannot be stored in the dietary department refrigerators. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Dietary staff will visually monitor the refrigerators/freezer for unallowed items throughout their shift. The Dietary Manager/designee will monitor dietary refrigerators and freezers for items not allowed in dietary refrigerators/freezers. Auditing to occur: all refrigerators/freezers will be visually observed and finding	

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	- Minimum Wash Temperature 120 degrees Fahrenheit, - Minimum Rinse Temperature 120 degrees Fahrenheit, and - Minimum Chlorine Required (PPM) 50. The "Dish Machine Temperature and Sanitizer Log Sample Form" for October and November 2024, was provided by the Dietary Manager on 11/26/24 at 2:32 P.M. The record indicated the wash temperature was below the recommended 120 degrees Fahrenheit on the following dates: - 11/02/24, 115 degrees, - 11/03/24, 119 degrees, - 11/04/24, 113 degrees, - 11/06/24, 115 degrees, - 11/08/24, 115 degrees, - 11/09/24, 115 degrees, - 11/10/24, 118 degrees, - 11/14/24, 115 degrees, - 11/15/25, 113 degrees, - 11/16/24, 118 degrees, and - 11/18/24, 115 degrees. The current "Food from Outside Sources" policy, with a reviewed date of 07/2023, was provided by the Director of Nursing (DON) on 11/26/24 at 10:54 A.M. The policy indicated, "...Visitors/family members will label food and beverages with the resident's name, room number and date. All food is to be stored in a suitable container...NO OUTSIDE FOOD WILL BE USED IN THE FOOD SERVICE DEPARTMENT..." The current "Personal Food Storage" policy, dated "2010", was provided by the Dietary		recorded weekly x's 30 days, then monthly x's 5 months for a total of 6 months of monitoring. Dietary staff will record dish machine temperature during use after every meal use of dish machine. The dietary manager will audit the temperature/chemical log of the dish machine. Auditing to occur logs will be reviewed no less than weekly x's 30 days, then monthly x's 5 months for a total of 6 months of monitoring. The results of the observations will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Any findings of ongoing non-compliance identified through the auditing process will be addressed through re-education, increase of frequency and/or duration of auditing until full compliance achieved. Compliance Date: 12/20/2024	

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	Manager on 11/26/24 at 11:34 A.M. The policy indicated, "...Food or beverage brought in from outside sources for storage in facility pantries, refrigeration units, or personal room refrigeration units will be monitored by designated facility staff for food safety..." 3.1-21(i)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to follow infection control guidelines related to isolation for 1 of 5 residents reviewed for isolation. (Resident 20) Findings include: During an observation and interview on 11/21/24 at 1:58 P.M., Resident 20 was propelling herself in her wheelchair out of the room. She indicated she was going to the shower room bathroom. It was a public bathroom that was shared with other residents, she had never used a bedside commode and had always used the public bathroom. During an observation on 11/21/24 at 2:01 P.M., Resident 20 was in the public bathroom in the shower room. Certified Nurse Aide (CNA) 4 donned gloves and the resident stood up from her wheelchair and CNA 4 assisted the resident with pulling her pants and brief down. The CNA removed the resident's soiled brief, placed it in a trash can, gathered a new brief from a shelf, and put it on the resident. When the resident was done, she stood up, and the CNA cleansed her and pulled up her pants. The resident sat back into her wheelchair. The CNA removed her gloves and opened the door for the resident to leave and	F 0880	***F 880 Infection Prevention and Control*** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The DON/designee will obtain an order for a follow up u/a to ensure resident #20's ESBL infection has resolved. If not resolved, appropriate tx will be requested from the provider. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Other residents who have active MRDO infections have the potential to be affected The DON/designee will complete an audit of active infections to ensure residents are on the appropriate type of isolation, if isolation is required. Any findings will be addressed by obtaining the appropriate order and	12/13/2024

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	washed her hands. The toilet was not cleaned after the resident had used it. During an interview on 11/21/24 at 2:08 P.M., CNA 4 indicated she was made aware if a resident was on any isolation precautions from the nurses and managers. If a resident was on isolation, she would wear a gown and gloves. Resident 20 was not on any type of isolation at that time. During an interview on 11/21/24 at 2:11 P.M., RN 3 indicated the shower bathroom was public and 24 of the 29 residents in the building used that bathroom. If a resident had Extended-spectrum B-lactamase (ESBL), a bacteria, in their urine, then they would be placed on isolation. The staff should wear a gown and gloves when assisting the resident to the bathroom. During an interview on 11/21/24 at 2:15 P.M., the Director of Nursing (DON) indicated is a resident had ESBL in their urine then they were placed on Enhanced Barrier Precautions (EBP). When a resident was placed on EBP then the staff were to wear a gown and gloves to provide care. The staff were made aware of resident's being on EBP through report and the signage on the resident door. If a resident had ESBL in their urine, then the bathroom should be disinfected after it was used. The clinical record for Resident 20 was reviewed on 11/21/24 at 1:56 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 08/30/24, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, hypertension, diabetes, non-Alzheimer's dementia, seizure disorder, depression, and schizophrenia.		ensuring appropriate infection control measures are in place. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON/designee will provide education to licensed and certified nursing associates on the requirement to implement the appropriate TBP for MRDO infections. Education will also be provided on infection control measures r/t sanitation and appropriate PPE use. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will review culture results from the lab to ensure appropriate TBP have been implemented when a resident has an MRDO infection. Auditing to occur: all cultures wkly x's 30 days, then 5 resident cultures result monthly x's 5 months for a total of 6 months of monitoring. The DON/designee to complete routine observations of nursing associates to ensure infection control measures are being followed, including appropriate PPE use. Observations to occur: 5 associates providing care to	

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	A Progress Note, dated 11/14/24 at 2:58 P.M., indicated the resident had a new order for Cipro (an antibiotic) 500 milligrams, twice a day, for 10 days for a Urinary Tract Infection (UTI). The resident was also on contact isolation for 10 days. A Progress Note, dated 11/14/24 at 8:21 P.M., indicated the resident was on an antibiotic for a UTI. The resident remained on contact isolation for ESBL. A Laboratory Report, dated 11/17/24, indicated the resident's urine was positive for ESBP resistance markers. The current facility policy titled, "Enhanced Barrier Precautions", dated August 2022, was provided by the DON on 11/22/24 at 2:08 P.M. The policy indicated "...Enhanced barrier precautions are utilized to prevent the spread of multi-drug resistant (MDROs)...EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply...Gloves and gown are applied prior to performing the high contact resident care activity..." 3.1-18(a)		residents with an MRDO wkly x's 30 days, then 5 associates providing care to residents with an MRDO monthly x's 5 months for a total of 6 months of monitoring. The DON/designee will complete routine monitoring of the CNA assignment sheets to ensure they have been updated to include residents who require TBP. Monitoring to occur: wkly x's 30 days, then 5 resident cultures result monthly x's 5 months for a total of 6 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Any findings of ongoing non-compliance identified through the auditing process will be addressed thru re-education, increase of frequency and/or duration of auditing until full compliance achieved.	
F 0912 SS=D Bldg. 00	483.90(e)(1)(ii) Bedrooms Measure at Least 80 Sq Ft/Resident Based on observation, record review, and interview, the facility failed to provide at least 80 sq ft (square feet) per resident for 2 of 11 resident rooms. (Rooms 1 and 3) 1. During an observation of Room 1 on 11/21/24 at 11:15 A.M., each of the four residents in this room	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 practice include**:	12/13/2024

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	had adequate space to move about the room and store their belongings. During an observation and interview on 11/25/24 at 2:08 P.M., Room 1, located in the licensed Skilled Nursing Facility/Nursing Facility (SNF/NF), was measured at 316 sq ft. 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. 2. During an observation of Room 3 on 11/21/24 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. During an observation on 11/25/24 at 2:11 P.M., Room 3, a licensed 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. During an interview on 11/26/24 at 1:54 P.M., the Administrator indicated she would like to continue with the room waivers. 3.1-19(l)(2)(A) 3.1-19(l)(3) 3.1-19(l)(8)		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 affect 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. ***The date the systemic changes will be completed: December 13, 2024***	