STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155847	A. BUILDING -- B. WING	12/06/2024

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/06/24 Facility Number: 000483 Provider Number: 155847 AIM Number: 100273470 At this Emergency Preparedness survey, Silver Memories Health Care was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 29 certified beds. At the time of the survey, the census was 28. Quality Review completed on 12/11/24	E 0000	K 000 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 December 31, 2024, for the life safety survey completed on December 6th, 2024. We respectfully request a paper review and will provide any additional information requested.	
E 0004 SS=C Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.1 Develop EP Plan, Review and Update Annually Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator and the Maintenance Director (MD) on 12/06/24 between 8:50 a.m. and 10:30: a.m., the EEP for the nurses station lacked a current annual	E 0004	**E 004** **It is the practice of this facility to assure that the facility develops, implement and reviews their emergency preparedness program that meets the State, Federal and local requirements.** ***The correction action taken for those residents found to be affected by the deficient practice include:***	12/31/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sharon Woods	Administrator	12/26/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155847	A. BUILDING -- B. WING	12/06/2024

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

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	update, and no date could be found since 08/01/22 to show the EPP for the nurses station was reviewed and updated within the last year. Based on an interview during records review, the Administrator stated the EEP that she maintains was reviewed recently and was present outside a binder in a paperclip. The Administrator copy was dated 09/13/24. During the survey no documentation was provided indicating the EPP for the nurses station was updated within the last year. This finding was acknowledged by the Administrator and Maintenance Director at the time of records review and again at the exit conference with the MD present.		On December 6th, 2024, the Emergency Preparedness binder date of review was corrected to the most recent date the facility emergency preparedness program was reviewed. ***Other residents that have the potential to be affected have been identified by:*** Potentially all residents could be affected but none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The maintenance director will monitor all facilities emergency preparedness program binders have the most recent review date, including the emergency preparedness program binder located in the nurses' station during his monthly compliance review. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The results of the maintenance compliance audits will be reviewed by the QAPI committee monthly X 3 months, then quarterly after 100% compliance is determined for 3 consecutive months. ***The date of the systemic changes will be completed:*** December 31st, 2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155847	A. BUILDING -- B. WING	12/06/2024

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

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E 0013 SS=C Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.1 Development of EP Policies and Procedures Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan's (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator and the Maintenance Director (MD) on 12/06/24 between 8:50 a.m. and 10:30: a.m., the EEP for the nurses station lacked a current annual update, and no date could be found since 08/01/22 to show the Policies and Procedures for the nurses station was reviewed and updated within the last year. Based on an interview during records review, the Administrator stated the EEP that she maintains was reviewed recently and was present outside a binder in a paperclip. The Administrator copy was dated 09/13/24. During the survey no documentation was provided indicating the Policies and Procedures for the nurse's station was updated within the last year. This finding was acknowledged by the Administrator and Maintenance Director at the time of records review and again at the exit conference with the MD present.	E 0013	**E 013** **It is the practice of this facility to assure that the facility develops and implement emergency preparedness policies and procedures.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** On December 6th, 2024, the Emergency Preparedness binder date of review was corrected to the most recent date the facility emergency preparedness program was reviewed. ***Other residents that have the potential to be affected have been identified by:*** Potentially all residents could be affected but none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The maintenance director will monitor all facilities emergency preparedness program binders have the most recent review date, including the emergency preparedness program binder located in the nurses' station during his monthly compliance review. ***The corrective action taken to monitor performance to assure***	12/31/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155847	A. BUILDING -- B. WING	12/06/2024

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			compliance through quality assurance is: The results of the maintenance compliance audits will be reviewed by the QAPI committee monthly X 3 months, then quarterly after 100% compliance is determined for 3 consecutive months. ***The date of the systemic changes will be completed:*** December 31st, 2024	
E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.1 Development of Communication Plan Based on record review and interview, the failed to review and update the Emergency Preparedness Plan's (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Administrator and the Maintenance Director (MD) on 12/06/24 between 8:50 a.m. and 10:30: a.m., the EPP's Communication Plan for the nurses station lacked a current annual update, and no date could be found since 08/01/22 to show the EPP's Communication Plan for the nurses station was reviewed and updated within the last year. Based on an interview during records review, the Administrator stated the EEP that she maintains was reviewed recently and was present outside a binder in a paperclip. The Administrator copy was dated 09/13/24. During the survey no documentation was provided indicating the EPP's Communication Plan for the nurses station was	E 0029	**E 029** **It is the practice of this facility to assure that the facility develops and maintains an emergency preparedness communication plan that complies with Federal, State and local laws and requirements.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** On December 6th, 2024, the Emergency Preparedness communication plan date of review was corrected to the most recent date the facility emergency preparedness program was reviewed. ***Other residents that have the potential to be affected have been identified by:*** Potentially all residents could be	12/31/2024

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	155847	A. BUILDING -- B. WING	12/06/2024

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SILVER MEMORIES HEALTH CARE	6996 SOUTH US421 VERSAILLES, IN 47042

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	updated within the last year. This finding was acknowledged by the Administrator and Maintenance Director at the time of records review and again at the exit conference with the MD present.		affected but none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The maintenance director will monitor all facilities emergency preparedness program binders have the most recent review date, including the emergency preparedness program binder located in the nurses' station during his monthly compliance review. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The results of the maintenance compliance audits will be reviewed by the QAPI committee monthly X 3 months, then quarterly after 100% compliance is determined for 3 consecutive months. ***The date of the systemic changes will be completed:*** December 31st, 2024	
E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.1 EP Training and Testing Based on record review and interview, the facility failed to review and updated the Emergency Preparedness Plan's (EPP) Training and Testing Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include:	E 0036	**E 036** **It is the practice of this facility to assure that the facility develops and maintains an emergency preparedness training and testing program that complies with Federal, State regulations and**	12/31/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	Based on records review and interview with the Administrator and the Maintenance Director (MD) on 12/06/24 between 8:50 a.m. and 10:30: a.m., the EPP's Training and Testing Plan for the nurses station lacked a current annual update, and no date could be found since 08/01/22 to show the EPP's Training and Testing Plan for the nurses station was reviewed and updated within the last year. Based on an interview during records review, the Administrator stated the EEP that she maintains was reviewed recently and was present outside a binder in a paperclip. The Administrator copy was dated 09/13/24. During the survey no documentation was provided indicating the EPP's Training and Testing Plan for the nurse's station was updated within the last year. This finding was acknowledged by the Administrator and Maintenance Director at the time of records review and again at the exit conference with the MD present.		**requirements.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** On December 6th, 2024, the Emergency Preparedness training and testing plan date of review was corrected to the most recent date the facility emergency preparedness program was reviewed. ***Other residents that have the potential to be affected have been identified by:*** Potentially all residents could be affected but none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The maintenance director will monitor all facilities emergency preparedness program binders have the most recent review date, including the emergency preparedness program binder located in the nurses' station during his monthly compliance review. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The results of the maintenance compliance audits will be reviewed by the QAPI committee monthly X 3 months, then quarterly after 100% compliance is determined	

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			for 3 consecutive months. ***The date of the systemic changes will be completed:*** December 31st, 2024	
K 0000 Bldg. 01	A Life Safety Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/06/24 Facility Number: 000483 Provider Number: 155847 AIM Number: 100273470 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 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. 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 has battery operated smoke detection in 9 of 11 resident sleeping rooms. The facility has smoke detection hardwired to the fire alarm system in Rooms 10 and 11. The facility has a capacity of 29 and had a census of 28 at the time of this visit. All areas where the residents have customary access were sprinkled and all areas providing	K 0000	K 000 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 December 31, 2024, for the life safety survey completed on December 6th, 2024. We respectfully request a paper review and will provide any additional information requested.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155847	A. BUILDING 01 B. WING	12/06/2024

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	facility services were sprinkled. Quality Review completed on 12/11/24			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Based on observation, the facility failed to ensure 1 of 4 exit locations were not obstructed in accordance with Section 7.1.10.2.1. Section 7.1.10.2.1 states that no furnishings, decorations or other objects shall obstruct exits or their access thereto. This deficient practice could affect at least 12 residents, staff and visitors exiting the hallway near resident room #10. Findings: Based upon observation and interview with the Maintenance Director (MD) during a facility tour on 12/06/24 between 10:35 a.m. and 12:50 p.m., the Hall corridor exit door near Resident Room #10 was obstructed with a wheeled "crash cart" which was parked in front of the double exit doors. The MD agreed and identified the cart as the crash cart stating that it is not normally positioned in front of the exit door. This deficient finding was acknowledged by the MD at the time of discovery and again with the MD present at the time of exit. 3.1-19(b	K 0211	**K 211** **It is the practice of this facility to assure that the facility's aisles, passageways, corridors, exit discharges, exit locations and accesses are in accordance and complies with Chapter 7 requirements.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** On December 6th, 2024, the wheeled crash cart was removed from the doble exit doorway to prevent obstruction. ***Other residents that have the potential to be affected have been identified by:*** Potentially all residents could be affected but none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The maintenance director will monitor all facility's exit doorways are free from obstruction during his monthly compliance review. ***The corrective action taken to monitor performance to assure compliance through quality***	12/31/2024

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			assurance is: The results of the maintenance compliance audits will be reviewed by the QAPI committee monthly X 3 months, then quarterly after 100% compliance is determined for 3 consecutive months. ***The date of the systemic changes will be completed:*** December 31st, 2024	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure 1. Based on observation and interview, the facility failed to ensure 1 of 4 corridors was not used as a hazardous area. Section 19.3.2.1.5(7) states that spaces larger than 50 square feet, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction shall be in an area separated from the corridor. This deficient practice could affect more than 8 residents, as well as staff and visitors in the corridor near the laundry area. Findings include: Based upon observation and interview with the Maintenance Director (MD) during a facility tour on 12/06/24 between 10:35 a.m. and 12:50 p.m., the corridor outside the laundry area, greater than 50 square feet contained a number of combustible items, such as 15-18 large boxes for base trim, construction materials and chairs. The corridor was being used to store combustible material which was estimated at least 60 square feet. The MD agreed the corridor was being used as storage of combustible materials.	K 0321	**K 321** **It is the practice of this facility to assure that the facility's hazardous areas are protected by a fire barrier having 1-hour fire resistance rating.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** All combustible items, including the large boxes of base trim, construction materials and chairs were removed from the hallway area. The laundry room door was repaired to ensure the self-closing device was working effectively. ***Other residents that have the potential to be affected have been identified by:*** Potentially all residents could be affected but none were identified. ***The measures or systematic changes that have been put into place to ensure that the***	12/31/2024

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	This deficient finding was acknowledged by the MD at the time of discovery and again with the MD present at the time of exit. 2. Based on observation and interview, the facility failed to ensure 1 of over 4 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 3 staff in the laundry room. Findings include: Based upon observation and interview with the Maintenance Director (MD) during a facility tour on 12/06/24 between 10:35 a.m. and 12:50 p.m., the corridor door to the laundry area, equipped with a self-closing device failed to self-close and latch into the door frame. The laundry area, greater than 50 square feet, contained large laundry bins and other combustible material. This deficient finding was acknowledged by the MD at the time of discovery and again with the MD present at the time of exit. 3.1-19(b)		***deficient practice does not recur include:*** The maintenance director will monitor all facility's hallways are clear from combustible items and self-closing doors are functioning adequately, during his monthly compliance review. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The results of the maintenance compliance audits will be reviewed by the QAPI committee monthly X 3 months, then quarterly after 100% compliance is determined for 3 consecutive months. ***The date of the systemic changes will be completed:*** December 31st, 2024	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to ensure 1 of 1 fire department connection sign was present and readable. NFPA 25 2010 edition states 13.7.1 fire department connections shall be inspected quarterly to verify the following: (1) The fire department connections are visible and accessible. (2) Couplings or swivels are not damaged and	K 0353	**K353** **It is the practice of this facility to ensure that the facility's maintenance and testing automatic sprinkler system are inspected, tested and maintained in accordance with 25. NFPA** ***The correction action taken for***	12/31/2024

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	rotate smoothly. (3) Plugs or caps are in place and undamaged. (4) Gaskets are in place and in good condition. (5) Identification signs are in place. (6) The check valve is not leaking. (7) The automatic drain valve is in place and operating properly. (8) The fire department connection clapper(s) is in place and operating properly. This deficient practice could affect all residents. Findings include: Based upon observation and interview with the Maintenance Director (MD) during a facility tour on 12/06/24 between 10:35 a.m. and 12:50 p.m., there was a fire department connection but the sign was missing. The MD stated that the holes for it were there but agreed the sign was missing stating that he may have it laying around somewhere. Based on interview at the time of the observations, the Maintenance Director agreed the FDC sign was missing. This deficient finding was acknowledged by the MD at the time of discovery and again with the MD present at the time of exit. 3.1-19(b)		***those residents found to be affected by the deficient practice include:*** A Fire Department Connection sign was posted at the outside fire department connection to ensure visible. ***Other residents that have the potential to be affected have been identified by:*** Potentially all residents could be affected but none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The maintenance director will monitor that the Fire Department Connection sign is posted and visible at the outside connection site, during his monthly compliance review. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The results of the maintenance compliance audits will be reviewed by the QAPI committee monthly X 3 months, then quarterly after 100% compliance is determined for 3 consecutive months. ***The date of the systemic changes will be completed:*** December 31st, 2024	

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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
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation, the facility failed to ensure 2 of 2 lights were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect staff and 15 residents in the activities/dining area adjacent to the riser room. Findings include: Based upon observation and interview with the Maintenance Director (MD) during a facility tour on 12/06/24 between 10:35 a.m. and 12:50 p.m., the ceiling lights in 1) in the nurses closet near Resident Room #2 and 2) in the corridor near Resident Room #7 were not provided with covers and had exposed electrical wiring. Based on interview at the time of the observations, the Maintenance Director acknowledged the lights were not provided with a cover and had exposed wires. This deficient finding was acknowledged by the MD at the time of discovery and again with the MD present at the time of exit. 3.1-19(b)	K 0511	**K 511** **It is the practice of this facility to ensure that the facility's lights are maintained in a safe operating condition.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** The light located in the nurse's supply closet and the light located near resident room #7 were replaced with new led lights that ensure they are covered, safe and functioning. ***Other residents that have the potential to be affected have been identified by:*** Potentially all residents could be affected but none were identified. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The maintenance director will monitor that lights are covered, safe and functioning, during his monthly compliance review. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The results of the maintenance compliance audits will be reviewed by the QAPI committee monthly X 3 months, then quarterly after	12/31/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155847	A. BUILDING 01 B. WING	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			100% compliance is determined for 3 consecutive months. ***The date of the systemic changes will be completed:*** December 31st, 2024	