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	10/05/2023

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: 10/05/23 Facility Number: 000483 Provider Number: 155847 AIM Number: 100273470 At this Emergency Preparedness survey, Silver Memories Health Care was found in 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 29. Quality Review completed on 10/11/23	E 0000		
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: 10/05/23 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	K 0000	K000 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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sharon Woods	Administrator	10/24/2023

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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	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 29 at the time of this visit. All areas where the residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 10/11/23		October 24, 2023, to the life safety survey completed on October 5th, 2023. We respectfully request a paper review and will provide any additional information requested.	
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 1 of 1 corridor doors to the main Dining Room would self close per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect over 10 residents,	K 0100	**K 100** **It is the practice of this facility to assure that all corridor doors self-close and latch.** ***The correction action taken for those residents found to be affected by the deficient practice***	10/24/2023

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	staff and visitors in the vicinity of the main Dining Room. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:05 p.m. to 12:45 p.m. on 10/05/23, the corridor door to the main Dining Room was held in the fully open position with a magnetic hold open device set to release with fire alarm system activation, latching hardware and a self closing device but the door failed to latch into the door frame when tested to self close multiple times. The door failed to fully self close and latch into the door frame because the latching mechanism on the door failed to protrude into the latching plate on the door frame. Based on interview at the time of the observations, the Maintenance Director agreed the corridor door to the main Dining Room did not self close and latch into the door frame when tested to self close multiple times. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		***include:*** On October 10th, 2023, the door knob on the corridor door to the main dining room was replaced to allow the door the latch when released from magnetic hold device. ***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 corridor doors, no less than monthly to ensure that all doors release and latch. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** An audit will be completed by maintenance or designee on all doors monthly. Any negative findings will be immediately remedied, and administrator notified. The results of these audits will be reviewed by the QAPI committee monthly X 3 months, then no less than quarterly after 100% compliance is determined for 3 consecutive months. ***The date the systemic changes will be completed:*** October 24th, 2023	

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K 0291 SS=D Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 1 of 19 battery powered emergency lighting systems was maintained in accordance with LSC Section 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70, National Electric Code. This deficient practice could affect 2 residents, staff and visitors in the main shower room by Room 11. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:05 p.m. to 12:45 p.m. on 10/05/23, the battery operated lighting system affixed to the wall above the corridor door in the main shower room by Room 11 failed to illuminate when its respective test button was pushed multiple times. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned battery powered emergency lighting system failed to illuminate when its respective test button was pushed multiple times. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference.	K 0291	**K 291** **It is the practice of this facility to assure that emergency lighting of at least 1½ hour duration is provided automatically as required.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** On October 10th, 2023, the emergency lighting unit located in the resident's main shower room by room 11 was replaced. ***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 emergency lighting, no less than monthly, to ensure that all emergency lighting is performing as required. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:***	10/24/2023

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	3.1-19(b)		An audit will be completed by maintenance or designee on all emergency lighting monthly. Any negative findings will be immediately remedied, and administrator notified. The results of these audits will be reviewed by the QAPI committee monthly X 3 months, then no less than quarterly after 100% compliance is determined for 3 consecutive months. ***The date the systemic changes will be completed:*** October 24th, 2023	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the second shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include:	K 0712	**K 712** **It is the practice of this facility to assure that the facility conducts quarterly fire drills at unexpected times under varying conditions.** ***The correction action taken for those residents found to be affected by the deficient practice***	10/24/2023

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	Based on review of "Fire Drill Report" documentation with the Administrator and the Maintenance Director during record review from 9:55 a.m. to 12:05 p.m. on 10/05/23, three of four second shift fire drills conducted within the most recent twelve month period on 02/02/23, 05/09/23 and 08/29/23 were conducted at, respectively, 3:30 p.m., 3:50 p.m. and 3:30 p.m. Based on interview at the time of record review, the Administrator and the Maintenance Director agreed the aforementioned second shift fire drills were not conducted at unexpected times under varying conditions. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		***include:*** On fire drill schedule has been reviewed to ensure fire drills are conducted at varying times. ***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 facility has reviewed and revised the monthly fire drill schedule to ensure varying times and varying conditions. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated to monitor the fire drills are conducted at varying times with varying conditions. The Maintenance Director or designee will complete 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 until 100% accuracy is indicated. The Quality Assurance	

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			Committee will continue to review the Performance improvement Tool until auditing tools show 100% compliance. ***The date the systemic changes will be completed:*** October 10th, 2023.	
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 Based on observation and interview, the facility failed to ensure 1 of 1 Therapy Room corridor doors was maintained in accordance with 19.7.5.6. 19.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied. (2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for	K 0753	**K 753** **It is the practice of this facility to ensure that doors are not decorated with combustible decorations.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** On October 5th, 2023, the purple plastic was removed from the therapy room door.	10/24/2023

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	Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source. (4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following: (a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 19.7.5.6(b), (c), or (d). (b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. (5)*They are decorations, such as photographs and paintings, in such limited quantities that a hazard of fire development or spread is not present. This deficient practice could affect over 5 residents, staff and visitors in the vicinity of the Therapy Room. Findings include:		***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 doors are not decorated with combustible decorations. All staff have been in-serviced on not decorating any of the doors with combustible decorations. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** An audit will be completed by maintenance or designee on all doors to ensure combustible decoration is not covering the doors. Any negative findings will be immediately remedied, and administrator notified. The results of these audits will be reviewed by the QAPI committee monthly X 3 months, then no less than quarterly after 100% compliance is determined for 3 consecutive months. ***The date the systemic changes will be completed:*** October 24th, 2023.	

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	Based on observations with the Maintenance Director during a tour of the facility from 12:05 p.m. to 12:45 p.m. on 10/05/23, purple plastic sheeting was hung on or affixed to the corridor door to the Therapy Room at the north end of the facility and covered the entire face of the corridor side of the door. The plastic sheeting did not have affixed documentation indicating the material was fire retardant or fire retardant treated. Based on interview at the time of the observations, the Maintenance Director stated he was not aware if the affixed plastic sheeting had been treated with fire retardant material and agreed fire resistance rating documentation for the plastic sheeting was not available for review. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if			

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	sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 1 of 1 indoor oxygen storage areas was in accordance with NFPA 99, Health Care Facilities Code. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet), but less than 85 cubic meters (3000 cubic feet), at STP shall comply with the requirements of 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.1 states storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible construction, with doors (or	K 0923	**K 923** **It is the practice of this facility to ensure indoor oxygen storage areas are in accordance with NFPA99, Health Facility Code.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** 2 of the “E” type oxygen cylinders were removed to maintain less than 300 cubic feet of oxygen	10/24/2023

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	gates outdoors) that can be secured against unauthorized entry. In addition, Section 11.3.2.7 states smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Director of Nursing Office. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:05 p.m. to 12:45 p.m. on 10/05/23, fourteen 'E' type oxygen cylinders were stored in racks and in proper cylinder carts in the Director of Nursing (DON) Office. Each 'E' type cylinder had an affixed sticker indicating 24 cubic feet of oxygen was the capacity of the cylinder. The corridor door to the DON Office was equipped with a lock on the door handle but the door was in the fully open position. In addition, an electric water heater was installed in the room and the oxygen cylinders were stored within five feet of combustible materials stored in the room. The room was not secured against unauthorized entry. Based on interview at the time of the observations, the Maintenance Director agreed over 300 cubic feet of oxygen was stored in the DON Office, the oxygen was stored in the same room as an electric heating element, oxygen was stored within five feet of combustible materials and the room was not secured against unauthorized entry. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		stored in the DON Office. ***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 no more than 300 cubic feet of oxygen is stored in the DON Office area and door remains locked. The maintenance man will remove all oxygen cylinders to an outside area that will be prepared in accordance to NFPA 99, Health Facilities Code. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** An audit will be completed by the maintenance or designee, no less than weekly, to ensure less than 300 cubic feet of oxygen is stored in DON area. Any negative findings will be immediately remedied, and administrator notified. The results of these audits will be reviewed by the QAPI committee monthly X 3 months, then no less than quarterly after 100% compliance is determined for 3 consecutive months. ***The date the systemic changes will be completed:*** October 24th,	

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			2023.	