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	11/28/2022

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: 11/28/22 Facility Number: 000483 Provider Number: 155847 AIM Number: 100273470 At this Emergency Preparedness survey, Silver Memories Health Care was found not 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 28. Quality Review completed on 12/01/22 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	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 16, 2022, to the life safety survey completed on November 28, 2022. We respectfully request a paper review and will provide any additional information requested. **It is the practice of this facility to assure that the facility maintains 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**	
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2),			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sharon Woods	Administrator	12/16/2022

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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	486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of			

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	the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.			
	Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2).	E 0006	**E006** **It is the practice of this facility to assure that the facility maintains an Emergency Plan which includes emerging infectious disease threats.** ***The correction action taken for those residents found to be affected by the deficient practice***	12/16/2022

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	In the Survey & Certification memo QSO: 19-06-ALL dated 02/01/19, the Centers for Medicare and Medicaid Services (CMS) updated Appendix Z of the State Operations Manual to reflect changes to add emerging infectious diseases to the definition of all-hazards approach and stated "Planning for using an all-hazards approach should also include emerging infectious disease (EID) threats. Examples of EIDs include Influenza, Ebola, Zika Virus and others". This deficient practice could affect all occupants. Findings include: Based on review of "Comprehensive Emergency Management Plan" documentation dated 08/01/22 with the Administrator and the Maintenance Director during record review from 9:45 a.m. to 12:15 p.m. on 11/28/22, a documented facility-based and community-based risk assessment addressing emerging infectious disease (EID) threats was not available for review. EID was not included in the current "Section II: Hazard and Security Vulnerability Assessment" section of emergency preparedness program documentation for the facility. Based on interview at the time of record review, the Administrator agreed emergency preparedness program documentation did not address emerging infectious diseases (EID) as part of the facility-based and community-based risk assessment as mandated by the CMS Survey & Certification memo QSO: 19-06-ALL. This finding was reviewed with the Administrator during the exit conference.		***include:*** The facility has reviewed and revised Section II: Hazard and Security Vulnerability Assessment to include emerging infectious disease threats. ***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 Section II: Hazard and Security Vulnerability Assessment to include emerging infectious disease threats. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated to monitor emerging infectious diseases are listed on the Section II: Hazard and Security Vulnerability Assessment list of facility-based and community-based risk assessment. The Maintenance Director or designee, will complete this tool weekly x 3, 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	

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			recommendations as needed based on the outcomes of the tools.The Quality Assurance Committee will review the Performance improvement Tool as indicated above and will increase to weekly monitoring if <90% accuracy show compliance. The Quality Assurance Committee will continue to review the Performance improvement Tool until auditing tools are showing 100% compliance, at which time the Quality Assurance Committee may decrease the monitoring increments. ***The date the systemic changes will be completed:*** December 16, 2022	
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: 11/28/22 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,	K 0000	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 16, 2022, to the life safety survey completed on November 28, 2022. We respectfully request a paper review	

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	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 harwired 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 facility services were sprinkled. Quality Review completed on 12/01/22		and will provide any additional information requested. **It is the practice of this facility to assure that the facility maintains 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**	
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, staff and visitors in the vicinity of the main Dining Room.	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 include:*** The corridor door to the main dining room was adjusted to allow	12/16/2022

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	Findings include: Based on observations with the Administrator during a tour of the facility from 12:15 p.m. to 1:00 p.m. on 11/28/22, 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 face of the door on the door handle side kept hitting the door frame. Based on interview at the time of the observations, the Administrator 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. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		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:*** December 16, 2022	
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour			

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	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 2 of 14 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 over 10 residents, staff and visitors if needing to exit the north exit door set of the facility in the Dining Room. Findings include: Based on observations with the Administrator during a tour of the facility from 12:15 p.m. to 1:00 p.m. on 11/28/22, the battery operated lighting system affixed to the exit sign above the north exit door set for the facility in the main Dining Room failed to illuminate when its respective test button was pushed multiple times. In addition, the battery operated lighting system in the exit discharge for the north exit door set for the facility from the main Dining Room also failed to illuminate when its respective test button was pushed multiple times. Based on interview at the time of the observations, the Administrator agreed the aforementioned battery powered emergency lighting systems each failed to illuminate when its respective test button was pushed multiple times. This finding was reviewed with the Administrator 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:*** The 2 emergency lighting systems were 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:*** 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	12/16/2022

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	3.1-19(b)		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:*** December 16, 2022	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure openings through 1 of 1 ceiling smoke barriers was protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes and similar items that pass through a floor/ceiling	K 0372	**K 372** **It is the practice of this facility to ensure smoke barriers are maintained without openings to maintain the fire resistance rating of the smoke barrier.** ***The correction action taken for***	12/16/2022

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	assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the main Dining Room. Findings include: Based on observations with the Administrator during a tour of the facility from 12:15 p.m. to 1:00 p.m. on 11/28/22, a two inch in diameter hole for the passage of the electrical conduit for a wall mounted exit sign was noted in the ceiling above the exit door to the corridor from the main Dining Room which exposed the attic above. Based on interview at the time of the observations, the Administrator agreed the aforementioned hole in the ceiling did not ensure the ceiling smoke barrier was protected to maintain the fire resistance rating of the smoke barrier. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		***those residents found to be affected by the deficient practice include:*** The 2 inch in diameter hole for the passage of the electrical conduit was filled with fire rated caulk to maintain a fire-resistant rating of the smoke barrier. ***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 audit the facility, no less than monthly, to monitor for openings that would prevent a fire-resistant rating. ***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:*** December 16,	

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