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	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Memories Health Care	6996 South Us421 Versailles, IN 47042

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to serve food in a sanitary manner related to hair net use for 3 of 4 kitchen observations. (Cook 4)Findings include:During an observation, on 12/18/2025 at 11:30 A.M., [NAME] 4 was standing in the kitchen in front of the stove stirring a pan of ham casserole. She had approximately 6 inches of long strands of hair on both sides of her face, hanging out of her hair net. During an observation, on 12/18/2025 at 11:50 A.M., [NAME] 4 was in the kitchen with approximately 6 inches of long strands of hair on the sides of her face, hanging out of her hair net. The cook was moving around the kitchen and temping food for the steam table. During an observation, on 12/22/2025 at 12:21 P.M., [NAME] 4 was in the kitchen. She had approximately 6 inches of long strands of hair on the sides of her face, hanging out of her hair net. During an interview, on 12/22/25 at 12:47 P.M., the Administrator indicated staff's hair should be in a hair net and not hanging out. The current facility policy titled, Employee Sanitary Practices, with a revision date of 7/2023, was provided by the Administrator on 12/22/2025 at 3:17 P.M. The policy indicated, .Hair nets or caps, covering all of the hair, mist be worn at all times while on duty .3.1-21(i)(3)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, the facility failed to implement an intervention after a fall for 1 of 13 residents' Care Plans reviewed. (Resident 25)Findings include:The clinical record for Resident 25 was reviewed on 12/22/2025 at 10:14 AM. A Quarterly Minimum Data Set (MDS) assessment, dated 12/12/2025, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, Huntington's disease, seizure disorder, anxiety, and depression. The resident had one fall since the last assessment. A Progress Note, dated 11/14/2025, indicated the resident had slid from her Broda chair (a specialized wheelchair) onto the floor on her buttocks. The fall was observed by a Certified Nurse Aide staff. The resident was assisted to her feet and placed back in the chair. There were no injuries. The clinical record lacked a documented intervention for the fall on 11/14/2025, until 12/19/2025 when a late entry note was placed by the Director of Nursing (DON) at 1:00 P.M. The note indicated the root cause of the fall was movements related to Huntington's disease caused her to slide easily to the floor. A new intervention was to reposition the resident as needed related to her movements related to her Huntington's disease. During an interview, on 12/22/2025 at 12:44 P.M., the DON indicated the care planned intervention should have been documented and implemented sooner than 12/19/2025. The current facility policy titled, Care Planning with a revision date of March 2022, was provided by the Administrator on 12/23/2025 at 9:35 A.M. The policy indicated, .The Interdisplinary team is responsible for the development of resident care plans.Resident care plans are developed according to the timeframes and criteria established.3.1-35(a)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to accurately address pharmacy recommendations for 1 of 5 residents reviewed for medications. (Resident 6)Findings include:The clinical record for Resident 6 was reviewed on 12/22/2025 at 12:59 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 12/09/2025, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, anemia, Chronic Obstructive Pulmonary Disorder (COPD), hemiplegia, and depression. A Consultant Pharmacist's Medication Regimen Review, dated 07/16/2025, indicated the following:The resident started taking Benefiber (a prebiotic supplement that supports digestive health) once daily. 1. Please add give with 8 oz fluid to the current directions. This will ensure proper administration to decrease the risk of impaction caused by inadequate fluid intake.2. Please adjust the administration time to be 2 hours before or 2 hours after all other medications. I also recommend adding this to the medication directions, so it does not get changed at a later date. This will ensure this medication will not affect how other medications work. If this was not possible, please address changing therapy with the physician. A handwritten note on the recommendation indicated the medication was discontinued on 06/25/2025.The resident's current medication orders were reviewed on 12/23/2025 at 2:30 P.M., and included, but were not limited to, the following:An open-ended order, with a start date of 07/16/2025, for Benefiber Powder, give one tablespoon by mouth in the morning. The resident's Electronic Medication Administration Record from 07/16/2025 through 12/23/2025 indicated the medication was administered daily at 8:00 A.M., the same time several other morning medications were administered, and lacked directions to administer the medication with 8 ounces of fluid.The current facility policy, titled .Long Term Care Pharmacy.Policy and Procedure., dated 05/20/2020, was provided by the Administrator on 12/23/2025 at 4:02 P.M. The policy indicated, .In collaboration with facility staff, the consultant pharmacist helps to identify, communicate, address, and resolve concerns and issues related to the provision of pharmaceutical services.3.1-25(i)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain complete and accurate resident records related to timely clinical assessments and documented medication administration for 2 of 12 residents reviewed for medical records. (Residents 10 and 6)Findings include: 1. The clinical record for Resident 10 was reviewed on 12/22/2025 at 12:45 P.M. An annual Minimum Data Set (MDS), dated [DATE], indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, anxiety, depression, and major depressive order with psychotic symptoms. The resident's current physician's orders included an open-ended order, with a start date of 03/06/2025, for Vraylar (an antipsychotic medication) 4.5 milligrams (mg) daily. The resident's Electronic Medication Administration Record (EMAR) indicated the resident received the medication daily as ordered. During an interview, on 12/23/2025 at 1:20 P.M., the Director of Nursing (DON) indicated when a resident received an antipsychotic medication, an Abnormal Involuntary Movement Scale (AIMS) assessment was required to be completed every six months. The assessment was completed in March 2025. An assessment should have been completed in September 2025. She completed the assessment today. During an interview, on 12/23/2025 at 1:57 P.M., the DON indicated there was not a facility policy related to AIMS assessments, but the facility followed federal guidelines related to required assessments for residents that received antipsychotic medications. 2. The clinical record for Resident 2 was reviewed on 12/19/2025 at 10:56 AM. A Significant Change MDS assessment, dated 11/03/2025, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, fractures, anemia, heart failure, hypertension, diabetes, hip fracture, and depression. The resident's physician's orders included, but were not limited to, the following: -Farxiga (a diabetic medication) 10 mg daily with a start date of 11/20/2025, a current order, and -Farxiga 10 mg daily with a start date of 10/29/2025, and a discontinue date of 12/15/2025. The resident's EMAR indicated the resident received the medication daily as ordered. A Consultant Pharmacist's Medication Regimen Review, dated 12/12/2025, indicated the Farxiga order was entered twice on the EMAR, and one needed to be removed. During an interview, on 12/23/2025 at 2:20 P.M., the DON and pharmacist review the delivery dates and amount of medication with each delivery. The resident had not received the medication twice each day. The order should have been clarified and corrected on the EMAR. During an interview, on 12/23/2025 at 2:25 P.M., Licensed Practical Nurse (LPN) 6 indicated the nurses knew to only give one Farxiga 10 mg tablet not two tablets. The current facility policy titled, MEDICATION ORDERS, was provided by the Administrator on 12/23/2025 at 4:03 P.M. The policy indicated, .The prescriber is contacted to verify or clarify an order (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(e.g., when the resident has allergies to the medication, there are contraindications to the medication, the directions are confusing).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview, the facility failed to follow infection control guidelines related to pericare (privates area cleaning) for 1 of 13 residents reviewed for infection control. (Resident 16)Findings include:During an observation, on 12/22/2025 at 10:40 A.M., Certified Nurse Aides (CNA) 2 and CNA 8 indicated to Resident 16 they were going to provide pericare. The resident was cleansed in the front appropriately. The resident was turned to her right side. There was stool present. CNA 2 wiped the resident from the back to the front multiple times. A new brief was applied, and the resident was made comfortable in her bed. During an interview, on 12/22/2025 at 10:50 A.M., CNA 2 indicated she should have wiped the resident from the front towards her back. The current, undated, facility policy titled, Perineal and/or Incontinence Care, was provided by the Administrator on 12/22/2025 at 3:49 P.M. The policy indicated, .Washing from front to back.3.1-18(b)

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [ROOM NUMBERS]) 1. During an observation of room [ROOM NUMBER] on 12/18/2025 at 11:15 A.M., each of the four residents in this room had adequate space to move about the room and store their belongings. During an observation and interview on 12/18/2025 at 1:58 P.M., room [ROOM NUMBER], a licensed SNF/NF (Skilled Nursing Facility/Nursing Facility) room, was measured at 299 sq ft. This room had 75 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 [ROOM NUMBER] on 12/18/2025 at 11:18 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 12/18/2025 at 2:05 P.M., room [ROOM NUMBER], a licensed SNF/NF room, was measured at 209 sq ft. This room had 69 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 12/18/2025 at 11:25 A.M., the Administrator indicated she would like to continue with the room waiver.3.1-19(l)(2)(A)3.1-19(l)(3)3.1-19(l)(8)