

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012619	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/26/2024
NAME OF PROVIDER OR SUPPLIER VILLAGES AT HISTORIC SILVERCREST THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1 SILVERCREST DRIVE NEW ALBANY, IN 47150		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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) COMPLETE DATE
{R 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Residential Complaint IN00434496 completed on 6/20/24.</p> <p>This visit was in-conjunction with a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey and a PSR to the State Residential Licensure Survey completed on 7/22/24.</p> <p>Residential Complaint IN00434496 - Corrected</p> <p>Survey date: August 26, 2024</p> <p>Facility number: 012619</p> <p>Residential Census: 30</p> <p>The Villages at Historic Silvercrest was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00434496.</p> <p>Quality review completed on August 27, 2024.</p>	{R 000}		

Indiana Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE