STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155813	A. BUILDING 00 B. WING	06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VILLAGES AT HISTORIC SILVERCREST THE	1 SILVERCREST DRIVE NEW ALBANY, IN 47150

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included an Investigation of Complaint IN00406418 and a State Residential Licensure Survey. Complaint IN00406418 - Federal/State deficiency related to the allegation is cited at F812. Survey dates: June 5, 6, 7, 8, 9, and 12, 2023 Facility number: 012619 Provider number: 155813 AIM number: 201238590 Census Bed Type: SNF/NF: 8 SNF: 40 Residential: 33 Total: 81 Census Payor Type: Medicare: 23 Medicaid: 8 Other: 17 Total: 48 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 16, 2023.	F 0000	The submission of this plan of correction does not indicate an admission by The Villages at Historic Silvercrest that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of The Villages at Historic Silvercrest. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for residential care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Victoria Roby Harper	Executive Director	06/29/2023

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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	comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to ensure a resident's blood sugar levels were tested at the appropriate time sequence as ordered by the physician, related to every two hours for three days, for 1 of 12 residents reviewed for quality of care. (Resident 32) Findings include: The clinical record for Resident 32 was reviewed on 6/9/23 at 9:54 a.m. The diagnosis included, but was not limited to, Diabetes Mellitus type 1. The Quarterly MDS (Minimum Data Set), dated 4/17/23, indicated the resident was severely cognitively impaired. The care plan, dated 11/1/22 and revised on 5/31/23, indicated Resident 32 was at risk for hypoglycemia and hyperglycemia related to Diabetes Mellitus. The interventions included, but were not limited to, laboratory test per physician orders, medications per orders, and monitor blood sugars per physician orders. The physician's orders, dated 1/3/23, indicated staff were to obtain a blood sugar q (every) 2 hours for 24 hours a day for 3 days. Fax over the results to the physician after completed for the 3 days. Twelve times a day at 4:00 p.m., 6:00 p.m., 8:00 p.m., 10:00 p.m., 12:00 a.m., 2:00 a.m., 4:00 a.m., 6:00 a.m., 8:00 a.m., 10:00 a.m.,12:00 p.m., and 2:00 p.m.	F 0684	1. Resident 32 was identified as having the potential to be affected by the cited deficiency. Resident's orders were reviewed and resident was assessed by MD. No adverse effects were noted. 2. All residents with orders for routine blood glucose testing had the potential to be affected. All residents testing records were reviewed by NP/MD. No adverse effects were noted. Nurses will be provided education on following physicians orders for blood glucose monitoring and accurately recording times of vitals taken when charting late entries. 3. As a measure of ongoing compliance, the DHS or designee will audit 3 residents with orders for blood glucose testing to ensure tests were performed as ordered with accurate time recorded for late entries, weekly x 4 weeks, then every 2 weeks x 2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance	07/14/2023

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	The Vital Records indicated the following: - On 1/3/23 at 12:41 the residents blood sugar was 230 mg/dL (milligrams per deciliter). The next blood sugar was not documented as completed until 4:16 p.m. - On 1/4/23 at 4:00 a.m., the residents blood sugar was 258 mg/dL. The next blood sugar was not documented as completed until 6:56 a.m. - On 1/4/23 at 6:56 a.m., the residents blood sugar was 251 mg/dL. The next blood sugar was not documented as completed until 10:08 a.m. - On 1/4/23 at 1:23 p.m., the residents blood sugar was 118 mg/dL. The next blood sugar was not documented as completed until 4:32 p.m. - On 1/4/23 at 5:59 p.m., the residents blood sugar was 192 mg/dL. The next blood sugar was not documented as completed until 8:55 p.m. - On 1/4/23 at 11:53 p.m., the residents blood sugar was 146 mg/dL. The next blood sugar was not documented as completed until 1/5/23 a.m., at 2:59 a.m. - On 1/5/23 at 7:32 a.m., the resident blood sugar was 74 mg/dL. The next blood sugar was not documented as completed until 11:15 a.m. - On 1/6/23 at 1:01 p.m., the residents blood sugar was 142 mg/dL. The next blood sugar was not documented as completed until 3:57 p.m. The MAR (Medication Administration Record), dated 1/4/23, 1/5/23, and 1/6/23, indicated the vital record document for the blood sugars and the MAR did not correspond. The staff initialed the BS by clicking on the box and entered the information on the vital record indicated the blood sugars were late. During an interview 6/9/23 at 10:48 a.m., LPN (Licensed Practical Nurse) 13 indicated If the physician ordered a blood sugar to be checked		Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months, if warranted, until 100% compliance met.	

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	every 2 hours, she would follow the physician's order and do the blood sugar as ordered. During an interview on 6/12/23 at 10:30 a.m., the DON (Director of Nursing) indicated she expected the staff to follow the physician's orders. During an interview on 6/12/23 at 12:00 p.m., LPN 14 indicated when staff charted off that they had taken the resident's blood sugar, they check it was completed at the scheduled time on the MAR and on the vital records the staff can correct the time to when the blood sugar was actually taken instead of the test showing up late with late charting. The resident's vital records indicated the resident's blood sugars were taken late on multiple occurrences and not every two hours as ordered. 3.1-37(a)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was			

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	necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, record review, and interview, the facility failed to ensure proper maintenance of a catheter and drainage system was off the floor for 1 of 2 residents reviewed for bowel and bladder. (Resident 29) Findings include: The record for Resident 29 was reviewed on 6/7/23 at 10:14 a.m. The diagnoses included, but were not limited to bacteremia, acute kidney failure, chronic kidney disease stage 3, altered mental status, urine retention, and neuromuscular dysfunction of bladder. The care plan, dated 2/2/23, indicated the resident used a catheter due to urinary retention related to neurogenic bladder. The interventions included, but were not limited to, maintain a closed system with urinary bag below the residents bladder and cover, observe for any signs of complication such	F 0690	1. Resident 29 was identified as having the potential to be affected by the cited deficiency. No adverse effects noted. Resident has a care plan for refusing catheter care and refusing to allow staff to move catheter bag/tubing. Tubing covered with Tubi-grip cloth and catheter bag placed in dignity bag to prevent direct contact with the floor when resident will not allow staff to provide repositioning of bag/tubing. 2. No other residents have catheters or were affected by the alleged deficient practice. Clinical staff will be provided education on catheter care to prevent UTI. 3. As a measure of ongoing compliance, the DHS or designee will visually observe all residents	07/14/2023

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	as UTI (Urinary Tract Infection), urethral trauma, strictures, bladder calculi or silent hydronephrosis, observe tubing and avoid any obstructions, and provide assistance with catheter care and change catheter per physician orders. The physician's order, dated 2/2/23, indicated the resident had a urinary catheter size 16 Fr (french) to the bedside related to urinary retention. The IDT (Interdisciplinary Team) note, dated 2/8/23 at 2:01 p.m., indicated a urinary catheter was placed due to the resident having intermittent catheters with high output and refusals to allow intermittent catheterization. A Foley catheter was ordered to be anchored by the resident's urologist. The nurse's note, dated 2/21/23 at 1:34 p.m., indicated the resident's urinalysis was positive for nitrates and the resident was started on omnicef 300 milligrams (mg) twice daily for 7 days. The nurse's note, dated 3/8/23 at 10:58 a.m., indicated the resident had a positive urinalysis and was started on an antibiotic for a UTI. The Quarterly MDS (Minimum Data Set) assessment, dated 4/14/23, indicated the resident was severely cognitively impaired. The nurse's note, dated 5/2/23 at 3:06 p.m., indicated the resident was started on vibramycin 100 mg twice daily for 15 days related to a UTI. During the initial tour on 6/5/23 at 10:10 a.m., Resident 29's catheter tubing was observed on the floor under his wheelchair where the resident could not have reached or manipulated the tubing		with catheters to ensure the bag and tubing are not touching the floor without a barrier weekly x 4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months, if warranted, until 100% compliance met.	

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	per himself. The resident was rolling back and forth near the tubing. He was unable to answer questions and seemed confused. During an observation on 6/7/23 at 1:00 p.m., Resident 29 was sitting in his wheelchair in his room. His Foley catheter was hanging underneath his wheelchair, where the resident could not have manipulated or reached the tubing. The tubing and the catheter bag were sitting directly on the floor with pale yellow urine in the tubing. During an interview on 6/8/23 at 11:05 a.m., LPN (Licensed Practical Nurse) 5 indicated the resident had a catheter and they were to make sure it had a dignity bag, was kept emptied, and that it was up off the ground and positioned below the bladder. She had been informed yesterday the catheter bag had been on the floor. During an interview on 6/8/23 at 11:12 a.m., LPN 15 indicated they were to make sure catheters were kept up off the ground. They put it on the inside of his chair, but not on the ground. They didn't want to pull it or have it tear open, and it was an infection risk if it was on the floor. During an interview on 6/8/23 at 11:17 a.m., the Assistant Director of Nursing indicated she had seen the resident's catheter bag low the day prior. He was capable of placing it on the floor and refused care a lot. She had not ever recalled using a secondary barrier between the bag and tubing and the floor. The Urinary Catheter Care policy, last revised 12/31/22, provided on 6/9/23 at 1:24 p.m. by the Corporate Nurse, included, but was not limited to, "... 11. Be sure the catheter tubing and drainage bag are kept off the floor..."			

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F 0695 SS=D Bldg. 00	3.1-41(a) 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure emergency respiratory supplies were available for a resident with a tracheostomy for 1 of 2 residents reviewed for Respiratory Care. (Resident 35) Findings include: The record for Resident 35 was reviewed on 6/6/23 at 1:13 p.m. The diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), pleural effusion, chronic respiratory failure with hypoxia, chronic bronchitis, chronic cough, shortness of breath, history of COVID-19, and encounter for attention to tracheostomy. The Admission MDS (Minimum Data Set) assessment, dated 3/23/23, indicated the resident was cognitively intact and required assistance with oxygen therapy, suctioning, and tracheostomy care. The care plan, initiated on 3/24/23, indicated the resident had a potential for complications related	F 0695	1. Resident 35 was identified as having the potential to be affected by the cited deficiency. No adverse effects were noted. Size 4 trach and obturator placed at head of bed along with current size 6 and obturator, with both clearly labeled. Resident's wife provided education on keeping both at head of bed. 2. No other residents were affected. Clinical staff provided education on emergency trach supplies kept at bedside. 3. As a measure of ongoing compliance, the DHS or designee will observe residents with tracheostomies to ensure emergency current size trach and one of a smaller size are hanging on the wall at the head of the bed weekly x 4 weeks, every 2 weeks x2 months, then monthly x 3 months.	07/14/2023

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	to having a tracheostomy. The interventions included, but were not limited to, assess lung sounds and report any wheezes, crackles, or decreased breath sounds; avoid unnecessary diagnostic or therapeutic procedures and devices; monitor and report signs of localized infection (localized swelling, redness, pain or tenderness, heat at the infected area, purulent drainage, loss of function); monitor and report signs of systemic infection (fever, lassitude or malaise, change in mental status, anorexia, nausea, headache, lymph node tenderness/enlargement); monitor vital signs as ordered and report any presence of fever; provide oral hygiene every shift; provide tracheostomy care as ordered; suction trach (tracheostomy) as ordered and needed for increased secretions; and use principles of infection control, universal and standard precautions. The nurse's note, dated 5/27/23 at 4:17 p.m., indicated the CNA (Certified Nurse Aide) called the nurse to the room when the resident's trach completely fell out. Another nurse assisted to replace the trach after cleansing and was unsuccessful. A smaller trach was inserted. The resident complained of feeling like his breathing was restricted and thought it was because of the smaller tube. He requested the larger tube be reinserted. Insertion of the larger tracheostomy was attempted by another nurse and unsuccessful. The smaller tracheostomy was cleansed and reinserted. The resident continued to complain of feeling like his breathing was restricted. The resident's vitals were within normal limits. The physician and family were notified and orders were given to send the resident to the hospital. He was not in any distress. During an observation on 6/5/23 at 12:00 p.m.,		4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months, if warranted, until 100% compliance met.	

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	Resident 35 was lying abed. The resident had a tracheostomy observed with the inner cannula and collar in place. A size six spare trach and obturator were hanging on the wall behind the resident's bed and to the left. There was no smaller size trach in sight. During an interview on 6/5/23 at 12:04 p.m., Resident 35 indicated on 5/27/23 he went into a coughing spell and he coughed so hard his trach was dislodged. The CNA was with him when it happened and immediately got the nurse. The nurse was either uncertain of what to do or hesitant to do it, so she got a second nurse. He was not in any distress. He was breathing fine. The second nurse said she knew what to do, but wasn't sure she could do it right so she sent for a third nurse. The third nurse came in after about 10 minutes and tried to put the original cannula in. The stoma had closed a little and she got resistance, so she got a smaller one. They thought it was a size 6, but it was actually a size 4. He was having a bit of trouble breathing and felt it was too small so he went to the hospital to see if they could put the original back in, however they as well encountered resistance. He followed up with his pulmonologist the following week and had a size 6 put back in. During an observation on 6/7/23 at 1:09 p.m., Resident 35 was lying abed. The resident had a tracheostomy observed with the inner cannula and collar in place. A size six spare trach and obturator were hanging on the wall behind the resident's bed and to the left. There was no smaller size trach in sight. During an interview on 6/9/23 at 9:40 a.m., the DON (Director of Nursing) indicated for a resident with a trach, they kept the obturator, the current			

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	size trach and a smaller size down, the ambu bag, and suction equipment at the bedside. During an observation on 6/9/23 at 9:44 a.m., Resident 35 was lying abed. The resident had a tracheostomy observed with the inner cannula and collar in place. A size six spare trach and obturator were hanging on the wall behind the resident's bed and to the left. There was no smaller size trach in sight. During an interview on 6/9/23 at 9:46 a.m., RN 16 indicated she had been trained on changing a tracheostomy prior to the resident's arrival to the facility, but had not ever had to do it before. She had confidence in her ability, but she would probably get someone to be in the room with her to ensure it was done properly as long as the resident was not in distress. He was to have different sizes of trachs available at the bedside. During an observation on 6/9/23 at 9:54 a.m., RN 16 entered the resident's room. She located the size 6 trach however could not locate the size 4 in the room. Upon being unable to locate the size 4, she went to find her supervisor. During an interview on 6/9/23 at 9:58 a.m., the AL (Assisted Living) Director 17 indicated she spoke to the DON and there was supposed to be both a size 6 and a size 4 trach in the room. She was initially unable to locate the size 4. It was not hanging at the bedside with the other spare trach. The resident told the staff he believed his family member may have a spare size 4 in the bottom of his dresser. Staff searched the drawers and were able to located the size 4 trach. AL Director 17 then indicated it needed to be hung up with the other spare trach on the wall as that was the uniform placement. They did not have a system			

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	for ensuring the trach supplies were where they were supposed to be. Resident 35 was their first tracheostomy patient in some time. During an interview on 6/9/23 at 10:00 a.m., RN 16 indicated over the head of the bed was the standard placement. In the bottom of the resident's dresser was not the ideal place to be. She indicated, "What if he wasn't able to tell us?" She had been trained to keep the spare trachs on the wall by the head of the bed. Guidance on Tracheostomy Tube Change was obtained from the National Institute for Health website on 6/12/23. The guidance included, but was not limited to, "... The equipment required for (I) tube change are... Two tracheostomy tubes of appropriate make or type, where one is the same size, and the other is smaller, which can be used when stomal obstruction or collapse is encountered..." 3.1-47(a)(6)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with			

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	155813	A. BUILDING 00 B. WING	06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VILLAGES AT HISTORIC SILVERCREST THE	1 SILVERCREST DRIVE NEW ALBANY, IN 47150

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	applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to ensure expired foods were removed from service related to the mustard, fruit cups and mango chunks. This deficient practice had the potential to affect 46 of 48 residents receiving regular diets. Findings include: During a tour of the kitchen on 6/5/23 at 9:45 a.m., with the Dietary Manager the following was observed: -In the dry goods storage room sitting on the dry goods storage shelf was a bottle of mustard with an indicated use by date 5/10/23. -The Dietary Manager indicated there was another bottle of the mustard open in the stand-alone refrigerator. The bottle had a use by date of 5/10/23. -In the steam tables' refrigerator, there were 2 fruit cups with a use by date of 6/4/23. -In the freezer there was an open bag of mango chunks with a hand-written use by date of 1/25/23. During an interview on 6/5/23 a 2:07 p.m., Resident D indicated last week she did have one instance where she got the wrong food, and then she got a	F 0812	1. Resident D was identified as having the potential to be affected by the cited deficiency. Expired fruit cups were disposed. 2. No other residents were affected by the cited deficient practice. Expired mustard, fruit cups and frozen mango chunks were disposed. All food items were inspected to ensure none were expired. Checklist for daily inspection of food items for expiration has been implemented. Dietary staff will receive education on food storage guidelines, disposing of expired foods, and daily checklist. 3. As a measure of ongoing compliance, the DFS or designee will observe all food items to ensure none are expired and that daily checklist for expired food items has been completed weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred	07/14/2023

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	fruit cup that had a sticker with a use by date for the previous day. It was prepared 4 days prior. During an interview on 6/9/23 at 8:11 a.m., the Dietary Manager indicated when new food supplies arrived it was first in and first out. The staff pushed the old food forward, so that the new food was behind the product. Every dietary staff was responsible for making sure the expired foods were removed. She had not been informed of any residents receiving expired food. The Food Safety and Handling policy, last reviewed June 2016, was provided by the ED (Executive Director) on 6/9/23 at 8:10 a.m. The policy included, but was not limited to, "... The growth of pathogenic bacteria at dangerous levels can result when potentially hazardous foods are held at refrigerated temperature for extended periods. To monitor and limit refrigeration time, refrigerated ready-to-eat (RTE) potentially hazardous food must be date marked to assure that the food is either consumed or discarded within seven days ..." This Federal tag relates to Complaint IN00406418. 3.1-21(i)(3)		percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months, if warranted, until 100% compliance met.	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure an electrical outlet was maintained in a safe, functioning manner during 2 of 2 observations of the laundry room. This deficient practice had the potential to affect all 48 residents	F 0921	1. No residents were affected. Laundry room outlet was replaced and relocated above the detergent dispensing system. 2. No residents were affected	07/14/2023

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	currently residing at the facility. Findings include: During an observation of the laundry room on 6/9/23 at 12:11 p.m., the electrical outlet behind the washing machines was observed to have black scorch marks on the two bottom electrical sockets. The top two sockets were unable to be visualized as they were currently in use with the detergent dispensers plugged into them. During an interview on 6/9/23 at 12:15 p.m., Laundry Aide 11 indicated one of the detergent dispensers had shorted out and they were having to load the detergent manually into the machine. She thought there was a work order in on the outlet. She believed the top two outlets were okay to use. She thought the Director of Plant Operations (DPO) and the Housekeeping Supervisor were aware. During an interview on 6/9/23 at 12:19 p.m., the Housekeeping Supervisor indicated he thought the plug had shorted out 3 months ago, right before the DPO went on leave. He was not sure if anyone looked at it. He wasn't there when it happened and didn't know what happened, but it was reported to the maintenance department and they were aware of it. He didn't know if it had been cleared for use. During an observation of the laundry room on 6/9/23 at 12:36 p.m. with the Assistant DPO, he indicated he did observe the scorch marks to the outlets. He removed the plugs from the top two outlets. The top left outlet was observed to have scorch marks under the plug and did appear to have melting damage to it. The detergent dispenser plug-end on the top right was observed		by the cited deficient practice. Staff provided education on placing work orders for broken equipment through TELS system. All outlets were inspected and no concerns were found. 3. As a measure of ongoing compliance, Director of Plant Operations or designee will perform visual inspection of all building outlets weekly x 4 weeks, every other week x 2 months, then monthly x 3 months. 4. As a quality measure, the DPO or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months, if warranted, until 100% compliance met.	

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	to have some melting damage to it. Heavy amounts of white substance was observed on the outlet, the water fixture hoses, and the floor beneath the outlet and dispensers. During an interview on 6/9/23 at 12:38 p.m., the Assistant DPO indicated he was not aware of issues with the plug in the laundry room. It was a concern, as the scorch marks would mean there was a shortage somewhere. He did not have any work orders for anything in the laundry department. He felt the white substance was from where the detergent dispenser was leaking onto the outlet. He believed the issue was the box being below the chemical dispensers. The scorch marks were coming from the plugs, because the box was caked with detergent residue. The bottom of the right dispenser was caked with detergent. He raked his hand across the bottom of the dispenser and copious amounts of white flaky substance was observed to fall to ground. He would not operate the three shorting outlets. The top left and both outlets on the bottom were non-operational. They needed to switch out the box and raise the conduit. During an interview on 6/9/23 at 12:45 p.m., Laundry Aide 11 indicated the dispenser on the right was non-functioning and it had been that way for a while. It had been that way since a prior employee had left back in October or November of 2022. Since then the device had been non-functioning and the outlets had been scorched. During an interview on 6/9/23 at 12:48 p.m., the ED (Executive Director) indicated she was not aware of any issues with the outlets. During an interview on 6/9/23 at 12:56 p.m., the			

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	Assistant DPO indicated he called the DPO and he didn't give him any idea of how long the outlet had been out, but they were calling an electric company to come and take care of it. The detergent was causing it to malfunction. The system had been out for some time. He thought there was a ticket for the dispenser. They received a quote to fix the dispenser and had not moved forward with it because they were waiting to put new dispensers in all of their facilities. They weren't proactive in switching out the dispenser that had caused the issue with the outlet in the meantime and they were not aware of it. It was a simple fix and could be repaired quickly. During an interview on 6/9/23 at 1:16 p.m., the Corporate Nurse indicated the ED had informed her they did not have any prior work orders for the electrical outlet. The Equipment Care Policy, last revised on 2/14/18, was provided on 6/9/23 at 1:24 p.m. by the Corporate Nurse. The policy included, but was not limited to, "... Procedures... Generate work orders through [Name of Maintenance Program] when repairs are needed on equipment..." The Receptacle Inspection policy, last revised on 3/1/19, was provided on 6/9/23 at 1:24 p.m. by the Corporate Nurse. The policy included, but was not limited to, "... Visually inspect the physically [sp.] integrity of the receptacle. Ensure ports are not damaged. If there is damage repair immediately and note repairs on the log. Record all findings on the log..." 3.1-19(a)(4)			
R 0000				

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Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Complaint IN00406418. Complaint IN00406418 - State deficiency related to the allegation is cited at R0273. Survey dates: June 5, 6, 7, 8, 9, and 12, 2023 Facility number: 012619 Residential Census: 33 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 16, 2023.	R 0000	The submission of this plan of correction does not indicate an admission by The Villages at Historic Silvercrest that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of The Villages at Historic Silvercrest. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for residential care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to ensure an electrical outlet was maintained	R 0144	1. No residents were affected. Laundry room outlet was replaced	07/14/2023

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	in a safe, functioning manner during 2 of 2 observations of the laundry room. This deficient practice had the potential to affect all 33 residents currently residing at the facility. Findings include: During an observation of the laundry room on 6/9/23 at 12:11 p.m., the electrical outlet behind the washing machines was observed to have black scorch marks on the two bottom electrical sockets. The top two sockets were unable to be visualized as they were currently in use with the detergent dispensers plugged into them. During an interview on 6/9/23 at 12:15 p.m., Laundry Aide 11 indicated one of the detergent dispensers had shorted out and they were having to load the detergent manually into the machine. She thought there was a work order in on the outlet. She believed the top two outlets were okay to use. She thought the Director of Plant Operations (DPO) and the Housekeeping Supervisor were aware. During an interview on 6/9/23 at 12:19 p.m., the Housekeeping Supervisor indicated he thought the plug had shorted out 3 months ago, right before the DPO went on leave. He was not sure if anyone looked at it. He wasn't there when it happened and didn't know what happened, but it was reported to the maintenance department and they were aware of it. He didn't know if it had been cleared for use. During an observation of the laundry room on 6/9/23 at 12:36 p.m. with the Assistant DPO, he indicated he did observe the scorch marks to the outlets. He removed the plugs from the top two outlets. The top left outlet was observed to have		and relocated above the detergent dispensing system. 2. No residents were affected by the cited deficient practice. Staff provided education on placing work orders for broken equipment through TELS system. All outlets were inspected and no concerns were found. 3. As a measure of ongoing compliance, Director of Plant Operations or designee will perform visual inspection of all building outlets weekly x 4 weeks, every other week x 2 months, then monthly x 3 months. 4. As a quality measure, the DPO or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months, if warranted, until 100% compliance met.	

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	scorch marks under the plug and did appear to have melting damage to it. The detergent dispenser plug-end on the top right was observed to have some melting damage to it. Heavy amounts of white substance was observed on the outlet, the water fixture hoses, and the floor beneath the outlet and dispensers. During an interview on 6/9/23 at 12:38 p.m., the Assistant DPO indicated he was not aware of issues with the plug in the laundry room. It was a concern, as the scorch marks would mean there was a shortage somewhere. He did not have any work orders for anything in the laundry department. He felt the white substance was from where the detergent dispenser was leaking onto the outlet. He believed the issue was the box being below the chemical dispensers. The scorch marks were coming from the plugs, because the box was caked with detergent residue. The bottom of the right dispenser was caked with detergent. He raked his hand across the bottom of the dispenser and copious amounts of white flaky substance was observed to fall to ground. He would not operate the three shorting outlets. The top left and both outlets on the bottom were non-operational. They needed to switch out the box and raise the conduit. During an interview on 6/9/23 at 12:45 p.m., Laundry Aide 11 indicated the dispenser on the right was non-functioning and it had been that way for a while. It had been that way since a prior employee had left back in October or November of 2022. Since then the device had been non-functioning and the outlets had been scorched. During an interview on 6/9/23 at 12:48 p.m., the ED (Executive Director) indicated she was not aware			

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	of any issues with the outlets. During an interview on 6/9/23 at 12:56 p.m., the Assistant DPO indicated he called the DPO and he didn't give him any idea of how long the outlet had been out, but they were calling an electric company to come and take care of it. The detergent was causing it to malfunction. The system had been out for some time. He thought there was a ticket for the dispenser. They received a quote to fix the dispenser and had not moved forward with it because they were waiting to put new dispensers in all of their facilities. They weren't proactive in switching out the dispenser that had caused the issue with the outlet in the meantime and they were not aware of it. It was a simple fix and could be repaired quickly. During an interview on 6/9/23 at 1:16 p.m., the Corporate Nurse indicated the ED had informed her they did not have any prior work orders for the electrical outlet. The Equipment Care Policy, last revised on 2/14/18, was provided on 6/9/23 at 1:24 p.m. by the Corporate Nurse. The policy included, but was not limited to, "... Procedures... Generate work orders through [Name of Maintenance Program] when repairs are needed on equipment..." The Receptacle Inspection policy, last revised on 3/1/19, was provided on 6/9/23 at 1:24 p.m. by the Corporate Nurse. The policy included, but was not limited to, "... Visually inspect the physically [sp.] integrity of the receptacle. Ensure ports are not damaged. If there is damage repair immediately and note repairs on the log. Record all findings on the log..."			

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R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure expired foods were removed from meal service related to mustard, fruit cups and mango chunks. This deficient practice had the potential to affect 33 of 33 residents receiving regular diets. Findings include: During a tour of the kitchen on 6/5/23 at 9:45 a.m., with the Dietary Manager the following was observed: -In the dry goods storage room sitting on the dry goods storage shelf was a bottle of mustard with an indicated use by date 5/10/23. -The Dietary Manager indicated there was another bottle of the mustard open in the stand-alone refrigerator. The bottle had a use by date of 5/10/23. -In the steam tables' refrigerator, there were 2 fruit cups with a use by date of 6/4/23. -In the freezer there was an open bag of mango chunks with a hand-written use by date of 1/25/23. During an interview on 6/5/23 a 2:07 p.m., Resident D indicated last week she did have one instance where she got the wrong food, and then she got a fruit cup that had a sticker with a use by date for the previous day. It was prepared 4 days prior.	R 0273	1. Resident D was identified as having the potential to be affected by the cited deficiency. Expired fruit cups were disposed. 2. No other residents were affected by the cited deficient practice. Expired mustard, fruit cups and frozen mango chunks were disposed. All food items were inspected to ensure none were expired. Checklist for daily inspection of food items for expiration has been implemented. Dietary staff will receive education on food storage guidelines, disposing of expired foods, and daily checklist. 3. As a measure of ongoing compliance, the DFS or designee will observe all food items to ensure none are expired and that daily checklist for expired food items has been completed weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance	07/14/2023

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	During an interview on 6/9/23 at 8:11 a.m., the Dietary Manager indicated when new food supplies arrived it was first in and first out. The staff pushed the old food forward, so that the new food was behind the product. Every dietary staff was responsible for making sure the expired foods were removed. She had not been informed of any residents receiving expired food. The Food Safety and Handling policy, last reviewed June 2016, was provided by the ED (Executive Director) on 6/9/23 at 8:10 a.m. The policy included, but was not limited to, "... The growth of pathogenic bacteria at dangerous levels can result when potentially hazardous foods are held at refrigerated temperature for extended periods. To monitor and limit refrigeration time, refrigerated ready-to-eat (RTE) potentially hazardous food must be date marked to assure that the food is either consumed or discarded within seven days ..." This State tag relates to IN00406418		Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months, if warranted, until 100% compliance met.	