CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155813	B. WING		06/12/2023	
		100010			00/12/2020	
NAME OF I	PROVIDER OR SUPPLIEF	3	STREET	ADDRESS, CITY, STATE, ZIP COD		
TWINE OF I	NO VIDER OR SETTELET		1 SILV	ERCREST DRIVE		
VILLAGE	S AT HISTORIC S	ILVERCREST THE	NEW A	ALBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	· ·	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
F 0000	REGUERITURE OF	A EDG IDENTIFICATION	1110		5.112	
1 0000						
Dida 00						
Bldg. 00	TT1: ::4 C	D CC C 1St	E 0000			
		Recertification and State	F 0000	The submission of this plan of		
		This visit included an		correction does not indicate a	n	
	_	mplaint IN00406418 and a State		admission by The Villages at		
	Residential Licensu	ire Survey.		Historic Silvercrest that the		
				findings and allegations conta	ined	
	Complaint IN00406	6418 - Federal/State deficiency		herein are accurate, true		
	related to the allega	ation is cited at F812.		representation of the quality o	f	
				care provided, and living		
	Survey dates: June	5, 6, 7, 8, 9, and 12, 2023		environment provided to the		
				residents of The Villages at		
	Facility number: 01	2619		Historic Silvercrest. The facilit	v	
	Provider number: 1			recognizes its obligation to pro	-	
	AIM number: 2012			legally and medically necessar		
	7 HWI Hamber: 2012	30370		care and services to its reside	•	
	Canaua Dad Tyma				IIIS	
	Census Bed Type:			in an economic and efficient		
	SNF/NF: 8			manner. The facility hereby		
	SNF: 40			maintains it is in substantial		
	Residential: 33			compliance with the requirement		
	Total: 81			of participation for residential	care	
				facilities. To this end, the plan	of	
	Census Payor Type	:		correction shall serve as the		
	Medicare: 23			credible allegation of compliar	nce	
	Medicaid: 8			with all state and federal		
	Other: 17			requirements governing the		
	Total: 48			management of this facility. It	is	
				thus submitted as a matter of		
	These deficiencies	reflect State Findings cited in		statute only. The facility		
	accordance with 41			respectfully requests from the		
				department a desk review for		
	Quality review com	upleted on June 16, 2023.		substantial compliance.		
	Quality leview con	ipieted on June 10, 2023.		Substantial compliance.		
F 0684	483.25					
SS=D	Quality of Care					
	1	of care				
Bldg. 00	§ 483.25 Quality of					
	1	a fundamental principle that				
	I annies to all treat	ment and care provided to	1	i	I	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

facility residents. Based on the

(X6) DATE

TITLE

Victoria Roby Harper Executive Director 06/29/2023

Any defiency statement 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 disclodays 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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07/07/2023 PRINTED: FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/12/2023 155813 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1 SILVERCREST DRIVE VILLAGES AT HISTORIC SILVERCREST THE NEW ALBANY, IN 47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 F 0684 Resident 32 was identified 07/14/2023 failed to ensure a resident's blood sugar levels as having the potential to be were tested at the appropriate time sequence as affected by the cited deficiency. ordered by the physician, related to every two Resident's orders were reviewed hours for three days, for 1 of 12 residents and resident was assessed by reviewed for quality of care. (Resident 32) MD. No adverse effects were noted. Findings include: 2. All residents with orders for routine blood glucose testing had The clinical record for Resident 32 was reviewed the potential to be affected. All on 6/9/23 at 9:54 a.m. The diagnosis included, but residents testing records were was not limited to, Diabetes Mellitus type 1. reviewed by NP/MD. No adverse effects were noted. Nurses will be The Quarterly MDS (Minimum Data Set), dated provided education on following 4/17/23, indicated the resident was severely physicians orders for blood cognitively impaired. glucose monitoring and accurately recording times of vitals taken The care plan, dated 11/1/22 and revised on when charting late entries. 5/31/23, indicated Resident 32 was at risk for As a measure of ongoing hypoglycemia and hyperglycemia related to compliance, the DHS or designee Diabetes Mellitus. The interventions included, but will audit 3 residents with orders were not limited to, laboratory test per physician for blood glucose testing to ensure orders, medications per orders, and monitor blood tests were performed as ordered sugars per physician orders. with accurate time recorded for late entries, weekly x 4 weeks, The physician's orders, dated 1/3/23, indicated then every 2 weeks x 2 months, staff were to obtain a blood sugar q (every) 2 then monthly x3 months. hours for 24 hours a day for 3 days. Fax over the As a quality measure, the results to the physician after completed for the 3 DHS or designee will review any days. Twelve times a day at 4:00 p.m., 6:00 p.m.,

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p.m.

Event ID:

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

IW5Q11

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findings and corrective action at

least quarterly and ongoing until

campus achieves one hundred

percent compliance in the campus Quality Assurance Performance

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED		
		155813	B. W	ING		06/12/	2023	
N	NOTHER OF STATE			STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIER	t			ERCREST DRIVE			
VILLAGE	S AT HISTORIC SI	LVERCREST THE		NEW AI	LBANY, IN 47150			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	_	DATE	
	The Vital Records i	ndicated the following:			Improvement meetings. The p			
	On 1/2/22 at 12:41	I the medidents blood arress vice			will be reviewed and updated			
	- On 1/3/23 at 12:41 the residents blood sugar was 230 mg/dL (milligrams per deciliter). The next				warranted. Ongoing monitoring will			
		t documented as completed			continue past 6 months, if			
	T	t documented as completed			warranted, until 100% complia	ince		
	until 4:16 p.m On 1/4/23 at 4:00 a.m., the residents blood sugar				met.			
	was 258 mg/dL. The next blood sugar was not							
	documented as completed until 6:56 a.m.							
		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							
	_	pleted until 4:32 p.m.						
		p.m., the residents blood sugar						
		e next blood sugar was not						
	_	pleted until 8:55 p.m.						
		3 p.m., the residents blood sugar						
	was 146 mg/dL. Th	e next blood sugar was not						
	documented as com	pleted 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 com	pleted until 11:15 a.m.						
	- On 1/6/23 at 1:01	p.m., the residents blood sugar						
	_	e next blood sugar was not						
	documented as com	pleted until 3:57 p.m.						
	The MAR (Medicat	tion Administration Record),						
	,	3, and 1/6/23, indicated the vital						
		r the blood sugars and the						
		spond. The staff initialed the						
		he box and entered the						
		vital record indicated the blood						
	sugars were late.	I See a marenton in crood						
	Dumin o o : i : t - : :	. 6/0/22 of 10:49 o I DNI						
	_	7 6/9/23 at 10:48 a.m., LPN						
	· ·	Nurse) 13 indicated If the blood sugar to be checked						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155813	B. WI	NG		06/12/	2023
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1 SILVERCREST DRIVE NEW ALBANY, IN 47150				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	IE.	DATE
		would follow the physician's ood sugar as ordered.					
	DON (Director of N	on 6/12/23 at 10:30 a.m., the Jursing) indicated she expected ne physician's orders.					
	14 indicated when s taken the resident's l completed at the schon the vital records to when the blood su	on 6/12/23 at 12:00 p.m., LPN staff charted off that they had blood sugar, they check it was needuled time on the MAR and the staff can correct the time ugar was actually taken nowing up late with late					
	resident's blood suga	records indicated the ars were taken late on multiple tevery two hours as ordered.					
	3.1-37(a)						
F 0690 SS=D Bldg. 00	§483.25(e) Inconti §483.25(e)(1) The resident who is continuously bowel on admission assistance to main or her clinical cond	continence, Catheter, UTI inence. It facility must ensure that intinent of bladder and on receives services and intain continence unless his dition is or becomes such not possible to maintain.					
	incontinence, base comprehensive as ensure that- (i) A resident who an indwelling cathounless the residen	a resident with urinary ed on the resident's esessment, the facility must enters the facility without eter is not catheterized at's clinical condition catheterization was					

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CENTE	RS FOR MEDICARE & MEDI	CAID SERVICES			OMB NO. 0938-039		
	TEMENT OF DEFICIENCIES PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155813	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 06/12/2023		
	E OF PROVIDER OR SUPPLI		STREET ADDRESS, CITY, STATE, ZIP COD 1 SILVERCREST DRIVE NEW ALBANY, IN 47150				
(X4) PRE	FIX (EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	indwelling cather one is assessed as soon as possibilities of catheterization is (iii) A resident who receives approping to prevent urinar restore continents. §483.25(e)(3) For incontinence, but comprehensive ensure that a restore	tion, record review, and ility failed to ensure proper catheter and drainage system for 1 of 2 residents reviewed for	F 0690	1. Resident 29 was identifias having the potential to be affected by the cited deficience. No adverse effects noted. Resident has a care plan for refusing catheter care and refuto allow staff to move catheter bag/tubing. Tubing covered wi Tubi-grip cloth and catheter baplaced in dignity bag to prever direct contact with the floor whresident will not allow staff to provide repositioning of bag/tu2. No other residents have catheters or were affected by alleged deficient practice. Clin staff will be provided education catheter care to prevent UTI. 3. As a measure of ongoin compliance, the DHS or desig	using rith ag nt nen ubing. e the nical n on		

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cover, observe for any signs of complication such

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will visually observe all residents

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155813	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/12/2023		
	ROVIDER OR SUPPLIER S AT HISTORIC SI		STREET ADDRESS, CITY, STATE, ZIP COD 1 SILVERCREST DRIVE NEW ALBANY, IN 47150				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION act Infection), urethral trauma,	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) With catheters to ensure the b	DATE		
	strictures, bladder c hydronephrosis, obs obstructions, and pr catheter care and ch orders. The physician's ord resident had a urina to the bedside relate The IDT (Interdisci			and tubing are not touching the floor without a barrier weekly weeks, then every other week months, then monthly x3 mond. As a quality measure, the DHS or designee will review a findings and corrective action least quarterly and ongoing uncampus achieves one hundre percent compliance in the car Quality Assurance Performan Improvement meetings. The percent content of the car quality Assurance Performan Improvement meetings.	e x 4 x 2 ths. ne any at ntil d npus ce		
	was placed due to the catheters with high intermittent catheter ordered to be anchourologist.	ne resident having intermittent output and refusals to allow rization. A Foley catheter was red by the resident's		will be reviewed and updated warranted. Ongoing monitorin continue past 6 months, if warranted, until 100% complia met.	as g will		
	nitrates and the resi 300 milligrams (mg	nt's urinalysis was positive for dent was started on omnicef) twice daily for 7 days.					
	indicated the reside and was started on a	ted 3/8/23 at 10:58 a.m., nt had a positive urinalysis an antibiotic for a UTI.					
	assessment, dated 4 was severely cognit	-					
	indicated the reside	ted 5/2/23 at 3:06 p.m., nt was started on vibramycin for 15 days related to a UTI.					
	Resident 29's cathet floor under his whe	ur on 6/5/23 at 10:10 a.m., er tubing was observed on the elchair where the resident hed or manipulated the tubing					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155813	JILDING	instruction 00	(X3) DATE : COMPL 06/12/	ETED
	PROVIDER OR SUPPLIEF		1 SILVE	ADDRESS, CITY, STATE, ZIP COD ERCREST DRIVE LBANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	per himself. The rest forth near the tubin questions and seem During an observat. Resident 29 was sit room. His Foley can his wheelchair, who manipulated or read and the catheter bag floor with pale yellow. During an interview (Licensed Practical had a catheter and the dignity bag, was ke off the ground and She had been inform had been on the floor to the strength of the ground and she had been on the floor to the strength of the ground and she had been on the floor to the strength of the ground and she had been on the floor to the strength of the ground and she had been on the floor to the strength of the ground and she had been on the floor to the strength of the ground and she had been on the floor to the strength of the ground and she had been on the floor to the strength of the ground and she had been on the floor to the strength of the ground and she had been on the floor to the strength of the ground and she had been on the floor the strength of the ground and she had been on the floor the strength of the ground and she had been on the floor the strength of the ground and she had been on the floor the strength of the ground and she had been information.	tion on 6/7/23 at 1:00 p.m., ting in his wheelchair in his theter was hanging underneath the tree the resident could not have thed the tubing. The tubing a were sitting directly on the tow urine in the tubing. You on 6/8/23 at 11:05 a.m., LPN Nurse) 5 indicated the resident they were to make sure it had a pt emptied, and that it was uppositioned below the bladder. The process of the tree to the tree to the positioned below the catheter bag	TAG			DATE
	indicated they were kept up off the grou of his chair, but not	to make sure catheters were and. They put it on the inside on the ground. They didn't ve it tear open, and it was an				
	Assistant Director of seen the resident's of He was capable of prefused care a lot. S	or on 6/8/23 at 11:17 a.m., the of Nursing indicated she had eatheter bag low the day prior. blacing it on the floor and the had not ever recalled using between the bag and tubing				
	12/31/22, provided Corporate Nurse, in	er Care policy, last revised on 6/9/23 at 1:24 p.m. by the icluded, but was not limited to, catheter tubing and drainage floor"				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPL	COMPLETED	
		155813	B. WI	NG		06/12/	2023
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				ERCREST DRIVE		
VIIIAGE	S AT HISTORIC SI	I VEDODEST THE					
VILLAGE	3 AT HISTORIC SI	LVERGREST THE		INEVV AI	LBANY, IN 47150		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCE	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
	3.1-41(a)						
F 0695	483.25(i)						
SS=D	Respiratory/Trache	eostomy Care and					
Bldg. 00	Suctioning	•					
	•	atory care, including					
	, .	e and tracheal suctioning.					
	•	nsure that a resident who					
	needs respiratory						
	•	•					
	tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the						
	comprehensive person-centered care plan,						
		s and preferences, and					
	483.65 of this subj						
	•	on, record review, and	F 06	505	Resident 35 was identifi	ha	07/14/2023
		ty failed to ensure emergency	1 00	193	as having the potential to be	cu	07/14/2023
		were available for a resident			affected by the cited deficiency	,	
		for 1 of 2 residents reviewed			No adverse effects were noted		
	for Respiratory Care				Size 4 trach and obturator place		
	for respiratory cure	c. (Resident 55)			at head of bed along with curre		
	Findings include:				size 6 and obturator, with both		
	i manigs merade.				clearly labeled. Resident's wife		
	The record for Resid	dent 35 was reviewed on 6/6/23			provided education on keeping		
		ignoses included, but were not			both at head of bed.	j	
	-	chronic obstructive pulmonary			2. No other residents were		
	·	usion, chronic respiratory			affected. Clinical staff provided		
	/· *	, chronic bronchitis, chronic			education on emergency trach		
		breath, history of COVID-19,			supplies kept at bedside.		
	-	tention to tracheostomy.				a	
	and encounter for at	tention to tracheostomy.			3. As a measure of ongoin	-	
	The Admission MD	S (Minimum Data Sat)			compliance, the DHS or design	iee	
		S (Minimum Data Set) /23/23, indicated the resident			will observe residents with		
					tracheostomies to ensure	and	
		ect and required assistance			emergency current size trach a		
	with oxygen therapy	y, suctioning, and			one of a smaller size are hang	•	
	tracheostomy care.				on the wall at the head of the b		
	The care -1 :- '-'	tad on 2/24/22 ind:4-141-			weekly x 4 weeks, every 2 weeks	eks	
	-	ted on 3/24/23, indicated the			x2 months, then monthly x 3		
	resident nad a poten	tial for complications related			months.		

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STATEMEN	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155813	B. W	ING		06/12/	2023
				CTDEET A	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
		W. V.ED.ODEOT T. I.E.			ERCREST DRIVE		
VILLAGE	S AT HISTORIC SI	ILVERCREST THE		NEW A	LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	rc	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	· C	DATE
	to having a tracheos	stomy. The interventions			4. As a quality measure, th	ie	
	included, but were not limited to, assess lung				DHS or designee will review a		
		ny wheezes, crackles, or			findings and corrective action	-	
	_	unds; avoid unnecessary			least quarterly and ongoing un		
		peutic procedures and devices;			campus achieves one hundred		
	-	signs of localized infection			percent compliance in the cam		
		redness, pain or tenderness,			Quality Assurance Performance	-	
		area, purulent drainage, loss			Improvement meetings. The p		
	of function); monitor and report signs of systemic				will be reviewed and updated		
	infection (fever, lassitude or malaise, change in				warranted. Ongoing monitoring		
	mental status, anorexia, nausea, headache, lymph				continue past 6 months, if	•	
	node tenderness/enlargement); monitor vital signs				warranted, until 100% complia	nce	
	as ordered and report any presence of fever;				met.		
	provide oral hygiene every shift; provide						
	tracheostomy care as ordered; suction trach						
	· ·	ordered and needed for					
		s; and use principles of					
		niversal and standard					
	precautions.						
	1						
	The nurse's note, da	ated 5/27/23 at 4:17 p.m.,					
		(Certified Nurse Aide) called					
		m when the resident's trach					
		Another nurse assisted to					
		ter cleansing and was					
	_	aller trach was inserted. The					
		d of feeling like his breathing					
	-	hought it was because of the					
		quested the larger tube be					
		of the larger tracheostomy					
	was attempted by an	_					
		maller tracheostomy was					
		rted. The resident continued					
		ing like his breathing was					
	-	lent's vitals were within normal					
		in and family were notified and					
		o send the resident to the					
	hospital. He was no						
	nospitai. He was no	n any disuess.					
	During on chargest	ion on 6/5/22 at 12:00 = ==					
	During an observati	ion on 6/5/23 at 12:00 p.m.,					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155813	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/12/2023
	ROVIDER OR SUPPLIER		STREET A 1 SILVE NEW A		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Resident 35 was lyi tracheostomy obser and collar in place. obturator were hang resident's bed and to smaller size trach in During an interview Resident 35 indicate coughing spell and was dislodged. The happened and immenurse was either unhesitant to do it, so was not in any distr. The second nurse sawasn't sure she coult third nurse. The thin minutes and tried to The stoma had close resistance, so she go it was a size 6, but i having a bit of trout too small so he wen could put the origin well encountered re his pulmonologist the size 6 put back in.	ng abed. The resident had a wed with the inner cannula A size six spare trach and ging on the wall behind the to the left. There was no a sight. If on 6/5/23 at 12:04 p.m., ed on 5/27/23 he went into a he coughed so hard his trach CNA was with him when it ediately got the nurse. The certain of what to do or she got a second nurse. He ess. He was breathing fine. And she knew what to do, but do do it right so she sent for a red nurse came in after about 10 put the original cannula in. ed a little and she got to a smaller one. They thought the was actually a size 4. He was be be breathing and felt it was at to the hospital to see if they all back in, however they as sistance. He followed up with the following week and had a			
	tracheostomy obser and collar in place. obturator were hang resident's bed and to smaller size trach in	ved with the inner cannula A size six spare trach and ging on the wall behind the to the left. There was no a sight.			
	DON (Director of N	or on 6/9/23 at 9:40 a.m., the Jursing) indicated for a resident ept the obturator, the current			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155813		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/12/2023	
	PROVIDER OR SUPPLIER			1 SILVE	ADDRESS, CITY, STATE, ZIP COD ERCREST DRIVE LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	size trach and a sma	aller size down, the ambu bag, ent at the bedside.					
	Resident 35 was lytracheostomy obser and collar in place. obturator were hang	ion on 6/9/23 at 9:44 a.m., ing abed. The resident had a red with the inner cannula A size six spare trach and ging on the wall behind the o the left. There was no a sight.					
	indicated she had b tracheostomy prior facility, but had not had confidence in h probably get someo to ensure it was don resident was not in	een trained on changing a to the resident's arrival to the ever had to do it before. She her ability, but she would one to be in the room with her ne properly as long as the distress. He was to have achs available at the bedside.					
	16 entered the resid	ion on 6/9/23 at 9:54 a.m., RN lent's room. She located the er could not locate the size 4 in ng unable to locate the size 4, r supervisor.					
	(Assisted Living) I to the DON and the size 6 and a size 4 t initially unable to le hanging at the beds The resident told the member may have a his dresser. Staff seable to located the steen indicated it new other spare trach or	ov on 6/9/23 at 9:58 a.m., the AL Director 17 indicated she spoke are was supposed to be both a rach in the room. She was ocate the size 4. It was not ide with the other spare trach, we staff he believed his family a spare size 4 in the bottom of arched the drawers and were size 4 trach. AL Director 17 eded to be hung up with the in the wall as that was the . They did not have a system					

PRINTED: 07/07/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							RM APPROVED IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155813	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/12/2023	
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	were supposed to be tracheostomy paties. During an interview indicated over the less standard placement resident's dresser we she indicated, "Whe she had been trained the wall by the head obtained from the Newbesite on 6/12/23 was not limited to,	v on 6/9/23 at 10:00 a.m., RN 16 nead of the bed was the a. In the bottom of the ras not the ideal place to be. nat if he wasn't able to tell us?"					
F 0812 SS=D Bldg. 00	size, and the other when stomal obstruencountered" 3.1-47(a)(6) 483.60(i)(1)(2) Food Procurement,Stors §483.60(i) Foods The facility must - §483.60(i)(1) - Procuper or constederal, state or local in the state of the state of the state of the state or local in	ocure food from sources idered satisfactory by					

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regulations.

applicable State and local laws or

gardens, subject to compliance with

(ii) This provision does not prohibit or prevent facilities from using produce grown in facility

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/12/2023 155813 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1 SILVERCREST DRIVE VILLAGES AT HISTORIC SILVERCREST THE NEW ALBANY, IN 47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 F 0812 07/14/2023 Resident D was identified failed to ensure expired foods were removed from as having the potential to be service related to the mustard, fruit cups and affected by the cited deficiency. mango chunks. This deficient practice had the Expired fruit cups were disposed. potential to affect 46 of 48 residents receiving No other residents were regular diets. affected by the cited deficient practice. Expired mustard, fruit Findings include: cups and frozen mango chunks were disposed. All food items During a tour of the kitchen on 6/5/23 at 9:45 a.m., were inspected to ensure none with the Dietary Manager the following was were expired. Checklist for daily observed: inspection of food items for expiration has been implemented. -In the dry goods storage room sitting on the dry Dietary staff will receive education goods storage shelf was a bottle of mustard with on food storage guidelines, an indicated use by date 5/10/23. disposing of expired foods, and daily checklist. -The Dietary Manager indicated there was another As a measure of ongoing bottle of the mustard open in the stand-alone compliance, the DFS or designee refrigerator. The bottle had a use by date of will observe all food items to 5/10/23. ensure none are expired and that daily checklist for expired food -In the steam tables' refrigerator, there were 2 fruit items has been completed weekly cups with a use by date of 6/4/23. x4 weeks, then every other week x2 months, then monthly x3 -In the freezer there was an open bag of mango months. chunks with a hand-written use by date of 1/25/23. As a quality measure, the DHS or designee will review any During an interview on 6/5/23 a 2:07 p.m., Resident findings and corrective action at D indicated last week she did have one instance least quarterly and ongoing until where she got the wrong food, and then she got a campus achieves one hundred

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155813		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/12/2023	
	PROVIDER OR SUPPLIER		1 SILV	ADDRESS, CITY, STATE, ZIP COD ERCREST DRIVE ALBANY, IN 47150	
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	the previous day. It During an interview Dietary Manager in supplies arrived it w staff pushed the old food was behind the was responsible for were removed. She residents receiving The Food Safety an reviewed June 2016 (Executive Director policy included, but growth of pathogen can result when pot held at refrigerated periods. To monitor refrigerated ready-thazardous food must that the food is either within seven days	d Handling policy, last b, was provided by the ED c) on 6/9/23 at 8:10 a.m. The t was not limited to, " The ic bacteria at dangerous levels centially hazardous foods are temperature for extended and limit refrigeration time, to-eat (RTE) potentially st be date marked to assure er consumed or discarded		percent compliance in the car Quality Assurance Performan Improvement meetings. The pwill be reviewed and updated warranted. Ongoing monitorin continue past 6 months, if warranted, until 100% compliamet.	ce blan as g will
F 0921 SS=D Bldg. 00	§483.90(i) Other E The facility must p sanitary, and com residents, staff an Based on observation failed to ensure and in a safe, functionin	anitary/Comfortable Environ Environmental Conditions provide a safe, functional, fortable environment for d the public. on and interview, the facility electrical outlet was maintained g manner during 2 of 2 laundry room. This deficient	F 0921	No residents were affect Laundry room outlet was replayed and relocated above the determined by the second dispensing system.	aced
		ential to affect all 48 residents		dispensing system. 2. No residents were affect	oted

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
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		l .	<u> </u>	CTDEET /	ADDRESS CITY STATE ZIR COD	l .	
NAME OF P	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD ERCREST DRIVE		
\/ \		ILVERCREST THE					
VILLAGE	S AT HISTORIC SI	LVERUREST THE		INEVV A	LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
	currently residing a	t the facility.			by the cited deficient practice.		
					Staff provided education on pl	_	
	Findings include:				work orders for broken equipn	nent	
					through TELS system. All outle	ets	
	-	ion of the laundry room on			were inspected and no concer	ns	
	-	., the electrical outlet behind the			were found.		
	_	was observed to have black			3. As a measure of ongoin	g	
		e two bottom electrical sockets.			compliance, Director of Plant		
	•	s were unable to be visualized			Operations or designee will		
	•	tly in use with the detergent			perform visual inspection of al		
	dispensers plugged	into them.			building outlets weekly x 4 we		
					every other week x 2 months,	then	
	_	v on 6/9/23 at 12:15 p.m.,			monthly x 3 months.		
	-	dicated one of the detergent			4. As a quality measure, th		
	-	ted out and they were having	DPO or designee will review any				
	_	t manually into the machine.			findings and corrective action		
	-	vas a work order in on the			least quarterly and ongoing ur		
		the top two outlets were okay			campus achieves one hundred		
		the Director of Plant			percent compliance in the can	-	
		and the Housekeeping			Quality Assurance Performand		
	Supervisor were aw	are.			Improvement meetings. The p		
		(10/02 + 10.16			will be reviewed and updated		
	-	v on 6/9/23 at 12:19 p.m., the			warranted. Ongoing monitoring	g will	
		ervisor indicated he thought			continue past 6 months, if		
		d out 3 months ago, right			warranted, until 100% complia	ince	
		nt on leave. He was not sure if			met.		
	-	He wasn't there when it					
		t know what happened, but it					
	-	maintenance department and					
	-	it. He didn't know if it had been					
	cleared for use.						
	During on absorrat	ion of the laundry room on					
	-						
	_	with the Assistant DPO, he serve the scorch marks to the					
		the plugs from the top two					
		outlet was observed to have					
	_						
		the plug and did appear to					
		ge to it. The detergent on the top right was observed					
	uispenser plug-end	on the top right was observed	1		l e e e e e e e e e e e e e e e e e e e		I

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 158813 NAME OF PROVIDER OR SUPPLIER VILLAGES AT HISTORIC SILVERCREST THE VILLAGES AT HISTORIC SILVERCREST THE SUMMARY STATEMENT OF DEFICIENCIE PRIEFR (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG RECHLATORY OR LOS EIDENTIFIVACINOSMATION IDENTIFICATION OF THE PRECEDED BY PULL TAG A SHILLAGES AS THE SILVER SI	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER VILLAGES AT HISTORIC SILVERCREST THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (RACH DEFICIENCY MOST BE PRECEDED BY FULL TAG TO Have some melting damage to it. Heavy and so have some melting damage to it. Heavy and so have some melting damage to it. Heavy and its have some melting damage to it. Heavy and its have some melting damage to it. Heavy and its mounts 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 score hards would mean there was a shortage somewhere. He did not have any work orders for anything in the haundry department. He felt the white substance was from where the detergent dispenser was leaking onto the outlet. If he helved the issue was the bax 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-uperational. They needed to switch out the box and raise the conduit. During an interview on 6/9/23 at 12/48 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 wis me as prior employee had left back in October or November of 2022. Since then the device had been non-functioning and the outlets had been secreted. During an interview on 6/9/23 at 12/48 p.m., the ED (fixecutive Director) indicated she was not aware of any issues with the outlets.	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
VILLAGES AT HISTORIC SILVERCREST THE VILLAGES AT HISTORIC SILVERCREST THE SUMMARY STATEMENT OF DEFICIENCE (CACH DEFICIENCY MUST BE PRECEDED BY UIL TAO REGULATORY OR LSC IDENTIFYING NFORMATION 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 order of the dispenser was leaking onto the outlet. He felt the white substance was from where the detergent dispenser was leaking onto the outlet. He believed the issue was the hox 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-fluctioning and it had been that way for a while. It			155813	B. WING		06/12/2023	
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

IW5Q11 Facility ID: 012619

If continuation sheet Page 16 of 23

PRINTED: 07/07/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155813	A. BUILDING B. WING	00 	COMPLETED 06/12/2023
	PROVIDER OR SUPPLIER		1 SILVE	ADDRESS, CITY, STATE, ZIP COD ERCREST DRIVE LBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Assistant DPO indice he didn't give him a had been out, but the company to come and detergent was causin system had been out there was a ticket for a quote to fix the district forward with it became with the productive in that had caused the meantime and they simple fix and could buring an interview Corporate Nurse incher they did not have the electrical outlet. The Equipment Cara 2/14/18, was provide Corporate Nurse. The not limited to, " Products through [Name when repairs are new to the corporate Nurse. The Receptacle Insp. 3/1/19, was provide Corporate Nurse. The Insp. 1 integrity of the not damaged. If their the company of the not damaged. If their the company to the control of the not damaged. If their the company to the control of the control of the not damaged. If their their the company to the control of the not damaged. If their their the company to the control of	cated he called the DPO and my idea of how long the outlet ey were calling an electric and take care of it. The ing it to malfunction. The tror some time. He thought for the dispenser. They received spenser and had not moved ause they were waiting to put all of their facilities. They switching out the dispenser issue with the outlet in the were not aware of it. It was a all be repaired quickly.			
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State Form Event ID: IW5Q11 Facility ID: 012619 If continuation sheet Page 17 of 23

PRINTED: 07/07/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155813		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/12/2023		
	ROVIDER OR SUPPLIER S AT HISTORIC SI		STREET ADDRESS, CITY, STATE, ZIP COD 1 SILVERCREST DRIVE NEW ALBANY, IN 47150				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
Bldg. 00	Survey. This visit in State Licensure Sur Complaint IN00406 Complaint IN00406 the allegation is cited Survey dates: June : Facility number: 01 Residential Census: These State Resider accordance with 416	33 atial Findings are cited in DIAC 16.2-5. pleted on June 16, 2023.	R 00	000	The submission of this plan of correction does not indicate ar admission by The Villages at Historic Silvercrest that the findings and allegations contain 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 necessar care and services to its resident in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirement of participation for residential caredible allegation of compliant 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.	ned vide y nts ents care of	
Bldg. 00	Sanitation and Sa (a) The facility sha a state of good rep	b(a) fety Standards - Deficiency fl be clean, orderly, and in pair, both inside and out, reasonable comfort for all					
		on and interview, the facility electrical outlet was maintained	R 0	144	No residents were affect Laundry room outlet was repla		07/14/2023

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155813	(X2) MULTIPLE C A. BUILDING B. WING	OO	(X3) DATE SURVEY COMPLETED 06/12/2023	
	ROVIDER OR SUPPLIER	LVERCREST THE	1 SILV	ADDRESS, CITY, STATE, ZIP COD ERCREST DRIVE ALBANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD II CROSS-REFERENCED TO THE APPROF DEFICIENCY)	(X5 DE COMPLE RIATE DATI	TION
IAG	in a safe, functioning observations of the practice had the pot currently residing a Findings include: During an observation of the practice had the pot currently residing a Findings include: During an observation of the practice of the properties of the plug had shorted before the DPO we anyone looked at it. happened and didn't was reported to the they were aware of cleared for use. During an observation of the properties of the propert	laundry room. This deficient ential to affect all 33 residents it the facility. Idential to affect all 33 residents it the facility. Idential to affect all 33 residents it the facility. Identify the electrical outlet behind the was observed to have black it two bottom electrical sockets. It were unable to be visualized the ty in use with the detergent into them. If on 6/9/23 at 12:15 p.m., dicated one of the detergent it manually into the machine. It was a work order in on the interest the two outlets were okay the Director of Plant and the Housekeeping fare. If on 6/9/23 at 12:19 p.m., the envisor indicated he thought indicated he thought indicated he thought in on leave. He was not sure if the wasn't there when it it know what happened, but it maintenance department and it. He didn't know if it had been it in of the laundry room on with the Assistant DPO, he	TAG	and relocated above the de dispensing system. 2. No residents were aff by the cited deficient practic Staff provided education on work orders for broken equithrough TELS system. All owere inspected and no concwere found. 3. As a measure of ongompliance, Director of Plan Operations or designee will perform visual inspection of building outlets weekly x 4 vevery other week x 2 monthmonthly x 3 months. 4. As a quality measure DPO or designee will review findings and corrective actic least quarterly and ongoing campus achieves one hund percent compliance in the concept of the continue past 6 months, if warranted, until 100% component.	ected e. placing pment utlets cerns bing all veeks, s, then the vany en at until red ampus ance e plan d as ring will	
	outlets. He removed	serve the scorch marks to the d the plugs from the top two outlet was observed to have				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155813	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 06/12/2023
NAME OF PROVIDER OR SUPPLIER VILLAGES AT HISTORIC SILVERCREST THE		1 SILV	ADDRESS, CITY, STATE, ZIP COD ERCREST DRIVE ALBANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
	have melting damaş dispenser plug-end to have some meltin amounts of white su	the plug and did appear to ge to it. The detergent on the top right was observed and damage to it. Heavy abstance was observed on the ture hoses, and the floor and dispensers.			
	Assistant DPO indicissues with the plug concern, as the scor was a shortage som work orders for any department. He felt where the detergent the outlet. He believe being below the che marks were coming box was caked with of the right dispenser and copic substance was obse would not operate to top left and both outlet.	on 6/9/23 at 12:38 p.m., the cated he was not aware of a in the laundry room. It was a such marks would mean there ewhere. He did not have any thing in the laundry the white substance was from a dispenser was leaking onto wed the issue was the box emical dispensers. The scorch a from the plugs, because the a detergent residue. The bottom er was caked with detergent. He was amounts of white flaky rived to fall to ground. He he three shorting outlets. The tilets on the bottom were mey needed to switch out the bonduit.			
	Laundry Aide 11 in right was non-funct way for a while. It I employee had left b 2022. Since then the	dicated the dispenser on the dioning and it had been that had been that way since a prior tack in October or November of the device had been did the outlets had been			
	_	on 6/9/23 at 12:48 p.m., the ED indicated she was not aware			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155813		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 06/12/2023		
	ROVIDER OR SUPPLIER S AT HISTORIC SI	LVERCREST THE	1 SILVI	ADDRESS, CITY, STATE, ZIP COD ERCREST DRIVE ALBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE COMPI	LETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DA	TE
	of any issues with the	he outlets.				
	During an interview Assistant DPO indicated he didn't give him a had been out, but the company to come a detergent was causis system had been out there was a ticket for a quote to fix the difforward with it because dispensers in a weren't proactive in that had caused the meantime and they simple fix and could buring an interview Corporate Nurse in the electrical outlet. The Equipment Care 2/14/18, was provide Corporate Nurse. The interview of the control of the cont	or on 6/9/23 at 12:56 p.m., the cated he called the DPO and any idea of how long the outlet arey were calling an electric and take care of it. The ang it to malfunction. The at for some time. He thought for the dispenser. They received spenser and had not moved asset they were waiting to put as witching out the dispenser issue with the outlet in the were not aware of it. It was a d be repaired quickly.				
	the log"	the log. Record an initings on				
			I			

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155813	B. W	ING		06/12/	2023
NAME OF PROVIDER OR SUPPLIER VILLAGES AT HISTORIC SILVERCREST THE		•	1 SILVE	ADDRESS, CITY, STATE, ZIP COD ERCREST DRIVE LBANY, IN 47150			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
R 0273 Bldg. 00	410 IAC 16.2-5-5. Food and Nutritior (f) All food prepara (excluding areas it maintained in accollocal sanitation an standards, including Based on observation failed to ensure experimental service related mango chunks. This potential to affect 3 is regular diets. Findings include: During a tour of the with the Dietary Management of the with the Dietary Management of the with the Dietary Management of the mustare refrigerator. The both 5/10/23. -In the steam tables cups with a use by continuous or the chunks with a hand-during an interview of the mustare of the mustar	nal Services - Deficiency ation and serving areas in residents ' units) are ordance with state and d safe food handling ing 410 IAC 7-24. In and interview, the facility irred foods were removed from to mustard, fruit cups and is deficient practice had the 3 of 33 residents receiving. Takitchen on 6/5/23 at 9:45 a.m., anager the following was a bottle of mustard with date 5/10/23. The property of the dry was a bottle of mustard with date 5/10/23. The property of the dry was another dopen in the stand-alone title had a use by date of the refrigerator, there were 2 fruit	R0	273	1. Resident D was identified as having the potential to be affected by the cited deficiency. Expired fruit cups were disposed. No other residents were affected by the cited deficient practice. Expired mustard, fruit cups and frozen mango chunk were disposed. All food items were inspected to ensure none were expired. Checklist for dainspection of food items for expiration has been implement Dietary staff will receive education food storage guidelines, disposing of expired foods, and daily checklist. 3. As a measure of ongoin compliance, the DFS or design will observe all food items to ensure none are expired and the daily checklist for expired food items has been completed we x4 weeks, then every other we x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review a findings and corrective action least quarterly and ongoing ur campus achieves one hundred percent compliance in the campus quality Assurance Performance.	y. ed. t ts e illy ted. ation d g neee chat l ekly eek	07/14/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING 00		00	COMPLETED	
155813		B. WING 06/12/2023			2023		
		l .		CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	₹		l	ERCREST DRIVE		
VILLAGE	S AT HISTORIC S	ILVERCREST THE			LBANY, IN 47150		
					1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG			DATE
	D :	(/0/02 + 0.11 + 1			Improvement meetings. The p		
	-	v on 6/9/23 at 8:11 a.m., the			will be reviewed and updated		
		dicated when new food vas first in and first out. The			warranted. Ongoing monitorin	g will	
	* *	l food forward, so that the new			continue past 6 months, if	nnoo	
	-	e product. Every dietary staff			warranted, until 100% complia met.	ance	
		making sure the expired foods			met.		
	•	had not been informed of any					
	residents receiving	•					
	residents receiving	expired rood.					
	The Food Safety an	d Handling policy, last					
	-	6, was provided by the ED					
		r) on 6/9/23 at 8:10 a.m. The					
	*	t was not limited to, " The					
	growth of pathogen	ic bacteria at dangerous levels					
		entially hazardous foods are					
	•	temperature for extended					
		r and limit refrigeration time,					
	refrigerated ready-t	o-eat (RTE) potentially					
hazardous food must be date marked to assure							
	that the food is eith	er consumed or discarded					
	within seven days .	"					
	This State tag relates to IN00406418						
	This State tag relate	58 IO 11NOU4U0418					

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