| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155813 | A. BUILDING **01**<br>B. WING _____ | R-C<br>**05/29/2025** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **VILLAGES AT HISTORIC SILVERCREST THE** | **1 SILVERCREST DRIVE**<br>**NEW ALBANY, IN 47150** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {K 000} | INITIAL COMMENTS<br><br>A Post Survey Revisit (PSR) to the investigation of Complaint Number IN00456847 conducted on 04/10/25 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).<br><br>Federal/State deficiencies related to the allegation cited at K324 and K711 were corrected on 04/16/25.<br><br>Survey Date: 05/29/25<br><br>Facility Number: 012619<br>Provider Number: 155813<br>AIM Number: 201238590<br><br>At this PSR to Complaint Survey Number IN00456847, The Villages at Historic Silvercrest was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<br><br>This five story facility with a basement was determined to be of Type II (222) construction and was fully sprinkled. The entire facility was surveyed with the exception of the Assisted Living on the fourth and fifth floors. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 54 and had a census of 44 for the Skilled Care Unit, and a capacity of 100 and had a total census of 77 for the entire facility | {K 000} | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155813 | A. BUILDING **01**<br>B. WING _____ | R-C<br>**05/29/2025** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **VILLAGES AT HISTORIC SILVERCREST THE** | **1 SILVERCREST DRIVE**<br>**NEW ALBANY, IN 47150** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {K 000} | Continued From page 1<br>at the time of this survey.<br><br>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.<br><br>Quality Review completed on 06/02/25 | {K 000} | | |