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	09/28/2023

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 the Investigation of Complaints IN00412762, IN00412995 and IN00416511. Complaint IN00416511 - No deficiencies related to the allegations were cited Complaint IN00412762 - No deficiencies related to the allegations were cited Complaint IN00412995 - Federal/State deficiencies related to the allegations are cited at F580 and F689 Survey dates: September 27 and 28, 2023 Facility number: 012619 Provider number: 155813 AIM number: 201238590 Census Bed Type: SNF/NF: 36 SNF: 12 Residential: 37 Total: 85 Census Payor Type: Medicare: 22 Medicaid: 12 Other: 14 Total: 48 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 30, 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 skilled health 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 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Victoria Roby Harper	Executive Director	10/13/2023

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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	(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15)			

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	Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to notify the physician of a critical laboratory result for 1 of 3 residents reviewed for Notification of Change. (Resident B) Findings include: The clinical record for Resident B was reviewed on 9/26/23 at 10:30 a.m. The diagnoses included, but were not limited to, presence of cardiac pacemaker, hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, heart failure, long term (current) use of anticoagulants, and chronic atrial fibrillation. The Annual MDS (Minimum Data Set) assessment, dated 3/23/23, indicated the resident was cognitively intact. The physician's orders, dated 4/10/23, 4/11/23 and 4/14/23 indicated the resident was to have a PT/INR (Prothrombin ratio and international normalized ratio) per coagulation machine. If the INR was greater than 8.0 staff were to obtain a laboratory blood draw. The resident was on Warfarin 3 mg (milligram) once a day for atrial fibrillation with a start date of 2/5/23. The care plan, dated 8/29/17 and last revised 3/29/23, indicated the resident was at risk for	F 0580	1 Resident B was identified as having the potential to be affected by the cited deficiency. No adverse effects noted. Resident B has been discharged from the facility. 2 All residents who have PT/INR labs performed had the potential to be affected. All residents who have had a PT/INR in the last 30 days were reviewed to ensure that critical results were reported timely to the provider. No residents were affected. Nurses will be provided education on provider notification guidelines. 3 As a measure of ongoing compliance, the DHS or designee will review all residents with PT/INR performed to ensure critical results are reported timely to the provider, 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	10/15/2023

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	excessive bleeding and bruising related to medications. The interventions included but were not limited to, notify the physician of abnormal bruising and or bleeding, administer medications as per current physician's orders, laboratory as ordered and notify the physician of abnormal laboratory results. The nurse's note, dated 4/7/23 at 2:21 a.m., indicated the resident was observed to have a critical high PT/INR during the shift. The results indicated the PT was 68.7 and the INR was 5.7. The laboratory results were put in the NP (Nurse Practitioner) binder for her to review in the a.m. when she came in. The nurse's note, dated 4/7/23 at 9:56 a.m., indicated the NP was notified for the resident's INR of 5.7. The NP ordered the warfarin 3 mg times 2 days and resume the warfarin 3 mg on Sunday then repeat the PT/INR on Monday. The nurse's note, dated 4/10/23 at 3:59 a.m., indicated the resident's PT/INR results were 74.4 and 6.2. The night shift communicated the laboratory results to the day shift nurse and placed the results in the NP binder. The nurse's note, dated 4/10/23 at 12:43 p.m., indicated the resident had a second critical laboratory result. The residents INR was critical at 6.2. The nurses note, dated 4/10/23 at 1:11 p.m., indicated the NP ordered a one-time dose of vitamin K and recheck the resident's PT/INR on 4/11/23 in the a.m. The nurse's note, dated 4/11/23 at 4:01 a.m., indicated the resident's laboratory results		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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	indicated the PT/INR was 32.6/2.7. The night shift nurse placed the results in the NP binder for her to review when she arrived at the facility and reported the laboratory results to the day shift nurse. The nurse's note, dated 4/11/23 at 10:38 a.m., indicated the resident's INR was rechecked and the result was 2.7. The NP was notified, and the resident's warfarin was held and ordered to be restarted on Wednesday at 2.5 mg and repeat the INR on Friday. During an interview on 9/26/23 at 12:20 p.m., RN 2 indicated if a laboratory result came back critical the NP (Nurse Practitioner) would be called immediately with the results. There would be an NP on call for the facility 24 hours a day. During an interview on 9/26/23 at 12:30 p.m., LPN 3 (Licensed Practical Nurse) indicated when a laboratory result for a PT/INR came back critical the NP would be called immediately. There would be a NP on call 24 hours a day and there would be no reason not to call or leave a message in the NP binder for the next day. The Notification of Change in Condition policy, dated 12/31/22, provided on 9/26 /23 at 10:30 a.m. by the DON (Director of Nursing, included, but was not limited to, "... To ensure appropriate individuals are notified of change in condition. The facility must inform the resident, consult with the resident's physician and if known notify the resident's legal representative when: 4. A critical lab value which requires an immediate intervention [excluding glucose values within the sliding scale] ..." This Federal tag relates to Complaint IN00412995.			

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	3.1-5(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review, and interview, the facility failed to ensure a resident received adequate supervision and interventions were properly implemented to prevent accidents for 1 of 3 residents reviewed for accidents. (Resident B) Findings include: The record for Resident B was reviewed on 9/26/23 at 10:30 a.m. The diagnoses included, but were not limited to, presence of cardiac pacemaker, hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, heart failure, long term (current) use of anticoagulants, and chronic atrial fibrillation. The Annual MDS (Minimum Data Set) assessment, dated 3/23/23, indicated the resident was cognitively intact. The physician's order, dated 2/6/23, indicated the resident was to have two staff assistance during toileting; and dated 7/29/21, the resident was to have two staff assistance if the resident has	F 0689	1 Resident B was identified as having the potential to be affected by the cited deficiency. Resident B has been discharged from the facility. 1 All residents who require assistance with transfers had the potential to be affected. All residents had a lift evaluation completed and care plans reviewed. No adverse effects were noted. Clinical staff will be provided with education on resident transfers. 2 As a measure of ongoing compliance, the DHS or designee will observe 3 residents receiving assistance with a transfer to ensure transfer assistance is provided according to the care plan, weekly x 4 weeks, then every 2 weeks x 2 months, then monthly x3 months. 3 As a quality measure, the DHS or designee will review any	10/15/2023

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	periods of weakness. The care plan, dated 8/29/27 and revised on 3/29/23, indicated the resident was at risk for falls related to decreased mobility, weakness, medications, edema, pain, and vertigo. Interventions included but were not limited to, a referral was made to psychiatric services and non-skid tape was added to the bathroom floor in front of the toilet, staff was educated on proper transfer for the resident, 2 staff assistance when toileting, offer 2-person assistance with transfers for periods of weakness, Physical therapy to evaluate for transfers, and use a gait belt when transferring the resident in case of sudden weakness. The nurse's note dated 2/3/23 at 10:24 a.m., indicated the resident reported that she fell on 2/2/23 while being assisted off the toilet. The resident stated she had some lower extremities weakness and indicated she was ok, but she was afraid of falling when being assisted with her toilet needs. The nurse's note, dated 2/6/23 at 9:14 a.m., the CNA (Certified Nursing Aide) indicated she lowered the resident down on the floor during a transfer. The resident was made a 2-person assistance when toileting. The nurse's note, dated 3/12/23 at 7:00 a.m., indicated the CNA called the residents nurse to the resident's room. The resident was observed sitting on the floor in an upright position with her back against the side of her bed. Both of her legs were in a normal position, and she was wearing gripper socks as ordered. Her right leg was straight in front of her, and her left leg was bent at the knee and her ankle was lying under her right		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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	ankle. Her wheelchair was close by her left side and facing her. The CNA stated that she was attempting to transfer the resident from her bed to her wheelchair when the resident's legs gave out. The CNA had both arms wrapped around the resident's waist and lowered her gently to the floor. The resident was tearful and complained that her left knee was hurting. During an interview on 9/26/23 at 12:15 p.m., CNA 5 indicated the CNA's had a patient care work sheet that they would go by. If a resident required, an assistance of 2 staff members there would be no reason not to transfer the resident with one staff member. The patient care work sheet would be updated by the nurses and the CNA's. During an interview on 9/26/23 at 12:20 p.m., RN 5 indicated fall prevention included nonskid footwear or shoes, no clutter in the resident's rooms and common areas, and monitor for mental changes. The nurse's and CNAs had a report sheet on the residents they would be caring for. If the resident required, an assistance of two staff members there would be no reason to transfer the resident with one person. The Fall Management policy, provided on 9/26/23 at 1:30 p.m. by the DON, included, but was not limited to, "... Purpose... mitigate fall risk factors and implement preventative measures... Procedure... 1... b. Care plan interventions should be implemented that address the resident's risk factors... 5. The resident care plan should be updated to reflect any new or change in interventions..." This Federal tag relates to Complaint IN00412995.			

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	3.1-45(a)(1)			