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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155813	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villages at Historic Silvercrest The	1 Silvercrest Drive New Albany, IN 47150

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on record review and interview, the facility failed to ensure residents were treated with dignity and respect for 1 of 12 residents reviewed for dignity. (Resident 52) Findings include:The record for Resident 52 was reviewed on 7/25/2025 at 9:56 a.m. The resident's diagnoses included, but were not limited to, arthrodesis status, cervical disc disorder with myelopathy of the cervical region, spondylosis with radiculopathy of the lumbar region, spinal stenosis of the lumbar region with neurogenic claudication, stage 3 chronic kidney disease, pulmonary fibrosis, severe morbid obesity, and anxiety disorder. The care plan, dated 6/2/25, indicated the resident was at risk for pain related to spinal stenosis, cervical fusion, and radiculopathy. The interventions, dated 6/2/25, included, but were not limited to, administer medications as ordered and notify the physician for any side effects observed or the lack of effectiveness, attempt non-pharmacological interventions, notify the physician of increased pain, observe for and record verbal and non-verbal signs of pain, and reposition the resident as needed. The admission Minimum Data Set (MDS) assessment, dated 6/3/25, indicated the resident was cognitively intact. The active diagnoses included, but were not limited to, anxiety disorder and depression. The Investigation Summary, dated 6/6/25, indicated the incident was reported on 6/11/25 at 1:29 p.m. by the resident. The resident reported to the Director of Social Service (DSS) that she had overheard QMA 5 mocking the resident on 6/6/25 at approximately 11:00 p.m. Upon notification to the DSS on 6/22/25, the staff member was immediately suspended pending further investigation. Witnesses were unable to verify Resident 52's statement and were unable to substantiate the claim. During an interview, on 7/25/25 at 12:07 p.m., QMA 4 indicated the resident came out of her room, upset and wanted her medications, but hadn't received them on time, and that QMA 5 was mocking her. QMA 5 was mocking the resident's crying sound, and the resident heard her mocking her and turned to say something to QMA 5, but QMA 4 wasn't sure what the resident said to QMA 5. QMA 5 indicated to QMA 4 that she wasn't able to figure out how to read the MAR on the computer at the medication cart. QMA 4 told her to call her nurse for any questions about what medications to administer and what dose. There was an order for one oxycodone routinely and one medication was prn (as needed). The resident was cognitively able to know what medication she was supposed to receive. QMA 4 saw the order, and informed the QMA 5 to contact her nurse, who was on speed dial and was easy to contact for help. Nurses were good at helping other staff at the facility. The MAR was written clearly for understanding which medications were the routine, and which medications were prn. QMA 4 tried to calm the resident down. During an interview, on 7/25/25 at 12:18 p.m., Licensed Practical Nurse (LPN) 3 indicated she was working on another floor, when the incident occurred. When she came to the floor where the resident was and the resident informed her that she wanted to leave the facility the night of the incident. The resident's family members were in her room and had been visiting the resident. The resident felt that she had received the wrong medication and that QMA 5 was making fun of her and mocking her. QMA 5 was suspended for 2 to 3 days at this time. The resident (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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NAME OF PROVIDER OR SUPPLIER Villages at Historic Silvercrest The		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Silvercrest Drive New Albany, IN 47150	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was calmed down and stayed the entire 20 days allotted for her stay. QMA 5 didn't feel that she was rude to the resident. During an interview, on 7/25/25 at 12:30 p.m., The ED indicated she was told that the resident was by her room's door and the QMA 5 was down the hall by the medication cart. The medication orders confused QMA 5 and she did provide poor customer service to Resident 52. The ED suspended QMA 5, pending the investigation. Your Rights and Protections as a Nursing Home Resident current policy, included, but was not limited to, . At a minimum, Federal law specifies that nursing homes must protect and promote the following rights of each resident. You have the right to: Be Treated with Respect: You have the right to be treated with dignity and respect . Get Proper Medical Care . To participate in the decisions that affects your care .3.1-32(a)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure narcotics were administered by physician's order, to obtain nursing permission, or document the narcotic count was accurate for 1 of 25 residents reviewed for medication administration. (Resident 52) Findings include:The record for Resident 52 was reviewed on 7/25/2025 at 9:56 a.m. The resident's diagnoses included, but were not limited to, arthrodesis status, cervical disc disorder with myelopathy of the cervical region, spondylosis with radiculopathy of the lumbar region, spinal stenosis of the lumbar region with neurogenic claudication, stage 3 chronic kidney disease, pulmonary fibrosis, severe morbid obesity, and anxiety disorder. The care plan, dated 6/2/25, indicated the resident was at risk for pain related to spinal stenosis, cervical fusion, and radiculopathy. The interventions, dated 6/2/25, included, but were not limited to, administer medications as ordered and notify the physician for any side effects observed or the lack of effectiveness, attempt non-pharmacological interventions, notify the physician of increased pain, observe for and record verbal and non-verbal signs of pain, and reposition the resident as needed. The admission Minimum Data Set (MDS) assessment, dated 6/3/25, indicated the resident was cognitively intact. The active diagnoses included but were not limited to anxiety disorder and depression. Since admission on [DATE], Resident 52 received opioids daily in the last 3 days. The physician's order, dated 5/31/25, indicated the nurse was to administer 10 milligrams (mg) of oxycodone every 12 hours for pain. The order was discontinued on 6/12/25. The physician's order, dated 5/31/25, indicated the nurse was to administer 10-325 mg, oxycodone-acetaminophen 2 tablets every 4 hours prn (as needed) for pain, with a maximum daily amount of 12 tablets. The order was discontinued on 6/13/25. The physician's order, dated 6/12/25, indicated the nurse was to administer 10 mg of oxycodone every 12 hours for pain. The order was discontinued on 6/13/25. The June 2025 Medication Administration Record (MAR) indicated Qualified Medication Aide (QMA) 5 administered 10 mg of oxycodone on 6/6/25 at 8:30 p.m. The review of the Controlled Drug Use Record sheet indicated QMA 5 signed the administration of two 20 mg oxycontin on 6/6/25 at or around 8:30 p.m. The order on the Controlled Drug Use Record sheet, indicated to administer 1 tablet twice daily for 20 mg of the oxycontin. The record lacked documentation on either Controlled Drug Use Record sheets for the administration of two tablets of Percocet on 6/6/25 by QMA 5. The Controlled Drug Use sheet for the 10 mg of oxycodone every 12 hours, could not be located by the facility. During an interview on 7/25/25 at 12:07 p.m., QMA 4 indicated the resident came out of her room, upset and wanted her medications, but hadn't received them on time. QMA 5 indicated to QMA 4 that she wasn't able to figure out how to read the MAR on the computer at the medication cart. QMA 4 told her to call her nurse for any questions about what medications to administer and what dose. There was an order for one oxycodone routinely and one medication was prn (as needed). The resident was cognitively able to know what medication she was supposed to receive. QMA 4 saw the order, and informed QMA 5 to contact her nurse, who was on speed dial and was easy to contact for help. Nurses were good at helping other staff at the facility. The MAR was written clearly for understanding which medications were the routine, and which medications were prn. QMA 4 tried to calm Resident 52 down. During an interview on 7/25/25 at 12:18 p.m., Licensed Practical Nurse (LPN) 3 indicated she was working on another floor, when the incident occurred. When she came to the floor where the resident was and the resident informed her that she wanted to leave the facility the night of the incident. Her family members were in her room and had been visiting Resident 52. The resident felt that she had received the wrong medication. During an interview on 7/25/25 at 12:30 p.m., The Executive Director (ED) indicated she was told that QMA 5 was delayed in (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	getting the original request for pain medication to the resident anyway and the resident had to make a second request for pain medication. QMA 5 had missed the prn pain medication window and then she administered the routine pain medication. She pulled 2 tablets of the routine oxycodone (two 10 mg tablets), instead of the prn oxycodone with acetaminophen (one 20 mg tablet). When the ED received the allegations, she suspended QMA 5, pending the investigation. During an interview on 7/25/25 at 12:41 p.m., the DON (Director of Nursing) indicated that QMA 5 administered two 10 mg (milligram) tablets of oxycodone instead of one 10 mg tablets of oxycodone. During an interview on 7/28/25 at 9:57 a.m., the DON indicated she could not find the Controlled Drug Use Record for the administration of the oxycodone being signed out on 6/6/25 by the QMA. The Guidelines for Narcotic Count policy, reviewed on 12/17/24, included, but were not limited to, . 3. The narcotic count sheet will indicate how many items are in the narcotic drawer and counted to ensure they are all present and accounted for. The count will be updated by two nurses to validate the changes with initials and date, as other items are added or removed . The Administration of PRN Medications policy, reviewed 12/13/14, included, but were not limited to, . 1. Prior to administration of PRN medication, the nurse shall review the physician orders and note any parameters for administration . 3. Documentation should reflect the reason for administrating the PRN medication. 4. If PRN medication is to be administered by a QMA the Standards of Practice for PRN, medication administration by a Qualified Medication Assistant shall be observed under the direction of licensed nurse. 5. Follow up should be noted to ensure the effectiveness and/or assess for adverse side effects. The Past noncompliance began on 6/6/25 at 10:20 p.m., and the deficient practice corrected by 6/6/25 after the facility implemented a systemic plan that included the following actions: The facility completed education for the QMA was initiated to have medication and dose verified by a second staff member prior to administration. Staff education was also provided to nursing staff. (6/6/25). The resident was monitored for side effects. (6/6/25). The Nurse Practitioner was notified (6/6/25). 3.1-25(a)