

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155813	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2024
NAME OF PROVIDER OR SUPPLIER Villages at Historic Silvercrest The		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>35732</p> <p>Based on record review and interview, the facility failed to monitor and appropriately document observation of the resident's urinary output for 1 of 2 residents reviewed for bladder incontinence. (Resident 11)</p> <p>Findings include:</p> <p>The record for Resident 11 was reviewed on 7/21/24 at 1:30 p.m. The diagnoses included, but were not limited to, sepsis, urinary tract infection, acute kidney failure, overactive bladder, and dementia.</p> <p>The care plan, dated 5/6/24, indicated the resident experienced episodes of incontinence. The interventions included, but were not limited to encourage fluids unless contraindicated, observe for signs and symptoms of UTI (Urinary Tract Infection) and notify the physician as needed, observe skin and report any signs of breakdown as needed, offer and assist with toileting as needed and/or per request, provide incontinence care as needed, and provide incontinence products as needed.</p> <p>The physicians' orders, dated 5/6/24, indicated to monitor urinary output due to the removal of the resident's indwelling Foley catheter three times a day. If there was no void in 8 hours, complete straight catheter using a regular Foley and if greater than 250 ml output, re-anchor the Foley catheter.</p> <p>The nurse's note, dated 5/6/24 at 9:20 p.m., indicated the resident's Foley catheter and midline were both discontinued during the shift. The resident tolerated both procedures well. A pressure dressing was applied to RUE (Right Upper Extremity) following removal of the midline. The resident would be monitored to ensure that she was able to void without difficulty.</p> <p>The IDT (Interdisciplinary Team) urinary notes, dated 5/7/24 at 11:50 a.m., indicated the resident was admitted with a catheter and an order was received to discontinue the catheter and monitor for output. If the resident did not void within 8 hours complete an in and out catheterization and anchor if over 250 mL (milliliters). If indicated do a urine dip and send out for a urinalysis and a culture and sensitivity if indicated.</p> <p>The review of the urinary output documentation indicated the following:</p> <p>(continued on next page)</p>

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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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- On 5/7/24 the resident urinated a medium amount of urine at 8:15 p.m. Documentation dated 5/8/24 at 12:42 a.m., indicated zero urine output. The resident urinated a large amount of urine at 1:49 p.m. The resident did not urinate for 15.5 hours.</p> <p>- On 6/12/24 the resident urinated a medium amount of urine at 2:21 a.m. Documentation dated 6/12/24 at 12:57 p.m., indicated zero urine output. The resident urinated a large amount of urine on 6/13/24 at 5:45 a.m. The resident did not urinate for 22.5 hours.</p> <p>The resident's record lacked documentation and monitoring of the resident's urine output during the long time durations of no voiding.</p> <p>The nurse's note, dated 5/12/24 at 5:48 p.m., indicated the emergency room called the facility and indicated the resident was admitted to the hospital with a diagnosis of sepsis, urinary tract infection and urinary retention.</p> <p>The Five Day Scheduled Minimum Data Set (MDS) assessment, dated 5/24/24, indicated the resident was cognitively severely impaired. The resident required maximum assistance with toileting.</p> <p>The nurse's note, dated 6/12/24 at 7:56 p.m., indicated during the p.m. medication pass the resident seemed more lethargic than baseline and the resident's family member agreed. The resident was alert and oriented times 2. Her vital signs were WNL (within normal limits), her temperature was 99.2 degrees Fahrenheit. The resident denied any pain and was able to take medication with no concerns. The resident took a long time to answer questions and would stare off at times and required redirection. Her respirations were even and unlabored. She had active bowel sounds in all 4 quadrants; her lungs were clear in all fields. The NP (Nurse Practitioner) was notified, and she ordered to obtain CBC (Complete Blood Count) and dip her urine and send to the laboratory if the results were positive.</p> <p>The review of the resident's fluid and food intake indicated the following:</p> <p>Breakfast</p> <ul style="list-style-type: none"> - On 5/8/24 the resident did not eat breakfast - On 6/12/24 the resident consumed 76% to 100% - On 7/10/24 the resident consumed 76% to 100% <p>Lunch</p> <ul style="list-style-type: none"> - On 5/10/24 the resident consumed 51% to 75% - On 6/12/24 the resident did not eat lunch - On 7/10/24 the resident consumed 26% to 50% <p>Dinner</p> <ul style="list-style-type: none"> - On 5/8/24 the resident consumed 1% to 25% <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- On 6/12/24 the resident consumed 76% to 100%</p> <p>- On 7/10/24 the resident consumed 26% to 50%</p> <p>Fluid intake</p> <p>- On 5/10/24 the resident's fluid intake was 480 mL</p> <p>- On 6/12/24 the resident's fluid intake was 720 mL</p> <p>- On 7/10/24 the resident's fluid intake was 1820 mL</p> <p>- On 7/10/24 the resident urinated a large amount of urine at 7:13 p.m. The documentation dated 7/10/24 at 11:08 p.m., indicated zero urine output. The resident urinated a large amount of urine on 7/11/24 at 4:57 a.m. The resident did not urinate for 9.5 hours.</p> <p>The clinical record indicated the resident was admitted to the hospital on 5/12/14 and 7/16/24.</p> <p>During an interview on 07/19/24 09:48 a.m., LPN (Licensed Practical Nurse) 5 indicated typically when a resident hadn't urinated for 8 hours the NP (Nurse Practitioner) would be notified. The facility was working with the NP to implement a time frame for when a resident should urinate.</p> <p>During an interview 7/19/24 at 11:04 a.m., the DON (Director of Nursing) indicated at the time the CNA (Certified Nursing Aide) documented in the record, the resident had not urinated. The CNA did not go back in and chart the output at the end of her shift. She indicated she educated the staff on documenting their charting at the end of their shift.</p> <p>The review of the staff education record indicated the following:</p> <p>- On 5/10/24 the documentation indicated CNA 6 documented on 5/8/24 at 12:30 a.m., the resident had no urine output. The CNA indicated that the resident had urinated around 4:00 a.m.</p> <p>- On 6/15/24 the documentation indicated the resident did not have an output on 6/12/24 on the night shift. CNA 7 documented on 6/12/24 at 10:45 p.m. The CNA indicated the resident urinated around 3:15 a.m.</p> <p>- On 7/13/24 the documentation indicated CNA 7 documented that the resident did not have a urine output on 7/10/24 on the night shift. This was documented on 7/10/24 at 11:00 p.m. The CNA indicated the resident urinated around 2:20 a.m.</p> <p>During an interview on 7/19/24 at 12:15 p.m., LPN 8 indicated the residents were checked and changed every 2 hours. She would not let a resident go any longer than 6 hours without urinating. She would call the doctor.</p> <p>During an interview on 7/19/24 at 12:30 p.m., CNA 9 indicated she would do her output charting at the end of her shift. She had been educated on when to chart the outputs. If she had a resident that did not urinate, she would tell the nurse.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>34309</p> <p>Based on observation, record review, and interview, the facility failed to ensure the kitchen equipment was clean and free from grease and food particles for 3 of 3 kitchen observations. This deficient practice had the potential to affect 46 residents currently residing on the 200 and 300 Halls.</p> <p>Findings include:</p> <p>During an initial tour of the kitchen on 7/15/24 at 9:28 a.m., the following was observed:</p> <ul style="list-style-type: none"> -A saucer sized whitish/yellow unknown mound was observed on the floor behind the double door heating oven. -Aluminum foil was in the drip pan under the stove top. - The stove top burners had a buildup of black charcoal, which had crackled on the surface area in the back of the burners. -The grill had black grease on the front surface of the grill grates and there was a buildup of black charcoal chunks between the grates. -The deep fryer had food particles on the front edge counter of the grease basin. -The vents had dust hanging down between the stove top and the steam table and preparation area. There were black areas in the vent holes above the area between the grill, stove, and heating oven, wrapping around above the side of the heating oven. -The floor in front of the stove, oven and grill was slippery with a greasy feel. There was a wet slippery puddle in front of the grill, which appeared to be oil. <p>During a second tour of the kitchen on 7/17/24 at 8:22 a.m., the following was observed:</p> <ul style="list-style-type: none"> -The aluminum foil was still observed in the drip pan under the stove top. -The stove top burners still had a buildup of black charcoal, which had crackled on the area in the back of the burners. -The grill still had black grease on the front surface of the grill grates and there was a buildup of black charcoal chunks on the grates. -The 2 drip pans under the grill had a heavy amount of black charcoal mounds and grease, which reached the underside of the grill. -The fryer had food particles on the front edge counter of the grease basin. <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The wire under the oven doors still had a 5-inch area without the cloth covering.</p> <p>-The vents still had dust hanging down between the stove top and the steam table and preparation area. There were black areas in the vent holes above the area between the grill, stove, and heating oven, wrapping around above the side of the heating oven.</p> <p>-The floor in front of the stove, oven and grill was still slippery with a greasy feel. There was a wet slippery puddle in front of the grill, which appeared to be oil.</p> <p>During a return tour of the kitchen on 7/19/24 at 8:52 a.m., the same issues were observed as well as the following:</p> <p>-Streaks of brown grease was observed down the right side of the stove.</p> <p>-The dust on the vents was hanging lower, between the stove top and the steam table and preparation area. There were black areas in the vent holes above the area between the grill, stove, and heating oven, wrapping around above the side of the heating oven.</p> <p>During an interview on 7/17/24 at 8:26 a.m., the Dietary Manager indicated the equipment was cleaned weekly with specific scheduled tasks, to be completed each day on both shifts. Once a week on Saturdays, the floors were cleaned. She did not mention that the equipment was cleaned as needed. She provided the schedule which indicated the following:</p> <p>-On Monday, the a.m. cook was to clean the convection oven and the p.m. cook was to clean the stovetop burners and boil out fryer.</p> <p>-On Tuesday, the a.m. cook was to clean the flat top, drip pans, and the stove backsplash. The p.m. cook was to clean the steamer.</p> <p>-The Friday p.m. cook was to clean the hood vents.</p> <p>During a follow up interview on 7/19/24 at 8:54 a.m., the Dietary Manager indicated staff would clean the equipment as needed along with the scheduled cleaning days and shifts, if a problem was observed. She felt that the stove would take time to clean the charcoal off the top. They had been chipping away at the buildup. The vents were cleaned on Fridays on the p.m. shift.</p> <p>The 15 Minutes of Cleaning policy, dated 2/7/23, included, but was not limited to, . For a 15-minute timeframe every day, your team will be working together on kitchen sanitation practices . Many other items need to be cleaned inside of our kitchens that are not on our weekly cleaning schedules .</p> <p>3.1-21(i)(3)</p>