STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G215		07/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCROFT SERVICES INC	321 S MARTIN ST MUNCIE, IN 47303

(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
W 0000 Bldg. 00	This visit was for a fundamental annual recertification and state licensure survey. Dates of Survey: July 27, 28, 29, 30 and 31, 2015. Facility number: 000741 Provider number: 15G215 AIM number: 100234840 This Federal deficiency also reflects a state finding in accordance with 460 IAC 9.	W 0000		
W 0240 Bldg. 00	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, interview and record review, the facility failed to develop written instructions in the client's Individual Support Plan (ISP) to staff about storage, cleaning and replacement of parts/filters for 1 of 1 sampled client who utilized bi pap (bi level positive	W 0240	A protocol was established, including written instructions for staff on frequency of cleaning the bi pap machine (including peripherals)and documentation. These instructions included monthly, weekly, and as needed care with replacing parts and	08/21/2015

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G215	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/31/2015
NAME OF PROVIDER OR SUPPLIER HILLCROFT SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 321 S MARTIN ST MUNCIE, IN 47303	

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	airway pressure) when sleeping (client #1). Findings include: Observations were conducted at the group home where client #1 lived on 7/27/15 from 4:17 P.M. through 6:19 P.M. Client #1's bi pap mask was laying on the floor under his bed. Client #1's record was reviewed on 7/29/15 at 2:29 P.M. Client #1's record indicated he had a diagnosis of Obstructive Sleep Apnea and utilized a bi pap mask/machine when sleeping to assist him with breathing. Client #1's Medication Administration Record (MAR) dated for 7/2015 indicated staff checked and documented hourly throughout the night to ensure client #1 had his mask on. Client #1's record did not include a protocol or written instructions for staff on frequency of cleaning the machine's humidifier tank, mask or tubing, how to clean the humidifier tank, mask, and tubing and when filters and other parts including mask and tubing were to be replaced or stored when not in use. On 7/30/15 at 1:30 P.M. the RN indicated there was no protocol, documentation of cleaning, storing or replacement of parts		documentation. All clients in the facility were reviewed for use of bi pap machines. Any clients identified as using a bi pap machine will have the same protocol implemented by a date no later than August 21, 2015. All clients across ICF/ID facilities are being reviewed and any clients identified, in current care, or future care will have the same protocol and documentation implemented. Any clients currently residing in an ICF/ID facility with Hillcroft Services that are identified as using a bi pap machine will have this same protocol implemented by a date no later than August 21, 2015. This protocol and documentation will be monitored, ongoing,at least weekly, by Group Home Manager. This protocol and documentation will be monitored, and physically observed (at least monthly), for 3 months by QIDP to ensure compliance with protocol and completion of documentation. If compliance is maintained for the 3 month period of QIDP monitoring, then monitoring will continue with Group Home Manager on an, at least, weekly basis. On a quarterly basis thereafter the QIDP will review documentation to insure compliance with the protocol.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G215	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/31/2015

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	for client #1's bi pap machine. An interview was conducted with the Residential Program Director (RPD) on 7/30/15 at 1:25 P.M. The RPD indicated there was no protocol in place for client #1's bi pap. 9-3-4(a)			