

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G215	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/06/2015
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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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(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
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K 0000  Bldg. 02	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 08/06/15</p> <p>Facility Number: 000741 Provider Number: 15G215 AIM Number: 100234840</p> <p>At this Life Safety Code survey, Hillcroft Services Inc. was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 32, New Residential Board and Care Occupancies.</p> <p>This one story facility was sprinklered. The facility has a fire alarm system with smoke detection in the corridors, common living areas and hard wired smoke detectors in all sleeping rooms. The facility has a capacity of six and had a census of five at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A,</p>	K 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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K 0130 Bldg. 02	<p>Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.56.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record, observation and interview, the facility failed to ensure 2 of 2 interior emergency lights were tested and the records of the testing maintained. NFPA 101 in 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall either be maintained or removed. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment requires a functional test be conducted at 30 day intervals and an annual test be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all clients in the facility as well as staff and visitors if the facility were required to evacuate in an emergency during a loss of normal power.</p>	K 0130	The documentation for emergency drill records has been modified to include documentation for testing of battery powered emergency lights. This documentation includes testing the battery powered emergency lights for 30 seconds each month and 90 minutes annually. All clients in the facility participate in monthly emergency drills, and as such, all battery powered emergency lights are tested for continuity of care for all residents in emergency situations. Adding the documentation to the monthly drill documentation will demonstrate that the lighting is tested for all clients. This documentation is being modified for all ICF/ID facilities within Hillcroft Services to ensure that the deficient practice will not recur. This is being implemented with all ICF/ID facilities by a date no later than 9.1.2015. This practice and documentation will be monitored, at least monthly, by the Group Home Manager ongoing to ensure compliance and	09/01/2015

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	<p>Findings include:</p> <p>Based on observation 08/06/15 at 1:32 p.m. with the Home Coordinator, the facility has two battery powered emergency lights. All battery powered emergency lights illuminated when the test button was depressed, however, no records of a thirty second monthly or ninety minute annual test were available for review. Based on interview concurrent with record review with the Home Coordinator it was acknowledged the aforementioned battery powered emergency lights had no documentation to verify the lights had been tested as described.</p>		<p>completion. QIDP will monitor documentation ongoing, at least monthly.</p>		