

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155203	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2014
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NAME OF PROVIDER OR SUPPLIER HILLCREST VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVE JEFFERSONVILLE, IN 47130
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K020000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 05/09/14</p> <p>Facility Number: 000110 Provider Number: 155203 AIM Number: 100271120</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Hillcrest Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>Hillcrest Village is a two story building with a finished partial basement. The building was constructed at two different times. The original building built in 1966 and constructed with mixed construction consisting of a two and one half inch thick concrete decks separating</p>	K020000	<p>Please find the enclosed plan of correction for the survey ending in 5/9/14. Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Due to the low scope and severity of the survey finding, please find sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance, feel free to contact me with any questions</p>	
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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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	<p>each floor, one hour fire rated smoke barrier walls, two fire barrier walls constructed of two hour construction on each level, brick exterior walls with metal studs and one half hour rated drywall, a mix of concrete and metal stud interior walls with one half hour rated drywall, and metal trusses and wooden rafters in the roof assembly. Based on the lowest construction type, the facility construction type was classified as Type V (111) construction. The original building was built with an open column foundation exposed at the entire south length of the facility. In 1974, a two story addition including the level 1 Transcare Unit and level 2 East Wing was constructed to the southeast of the original building and the column foundation was converted into a poured finished partial basement for physical therapy and is also of Type V (111) construction. Because the original building and the addition are the same type of construction, the facility was surveyed as one building.</p> <p>The facility is fully sprinkled. The facility has a fire alarm system with smoke detection on all levels including in the corridors, in spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 180 and had</p>			

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K020020 SS=E	<p>a census of 115 at the time of this survey.</p> <p>All areas where residents have customary access were sprinkled. All areas providing facility services were sprinkled except the detached laundry building and storage shed.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/13/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1.</p> <p>Based on observation and interview, the facility failed to maintain the vertical opening protection for 2 of 4 exit stairwells. LSC 8.2.5.2 requires enclosure of vertical openings including stairwells with fire barrier walls with a fire resistance rating of at least one hour. This deficient practice could affect 36 residents who reside on the first floor Moving Forward Hall and any residents</p>	K020020	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:A. The door closure in the moving forward hall was adjusted by the maintenance director on 5/20/2014. The door now closes completely and latches leaving no gapB After inspecting The administration Hall door on 5/20/2104, a fire rating label was</p>	05/31/2014

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K020025 SS=E	<p>using the first floor Administration Hall.</p> <p>Findings include:</p> <p>Based on observations on 05/09/14 during a tour of the first floor with the maintenance supervisor from 11:05 a.m. to 12:10 p.m., the Moving Forward Hall stairway door failed to self close and latch into the door frame, leaving a one inch gap along the latching side of the door. Furthermore, the Administration Hall stairway door lacked a fire resistance rating label. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 05/09/14 at 1:55 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>		<p>found to be painted over Maintenance supervisor removed paint from door to bring it back into compliance with K020.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.All residents have the potential to be affected by this practice.Maintenance director was in-serviced on 5/22/2014 related to the requirements of K020 by Jay Nowlin, AIT. All doors were inspected and found to be closing and leaving no gap after adjustment/repair and had appropriate labeling.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.The preventative maintenance log has been revised to include Inspection of enclosure of vertical openings; The Maintenance supervisor will visually inspect all vertical fire doors for closure and gaps monthly.How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.The maintenance director will complete the Environmental safety CQI audit weekly x4 weeks starting on 5/22/2014 and monthly x 6 months The CQI committee will determine the need for further review</p>		

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	<p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 2 of 33 basement room wall smoke barriers and 1 of 1 ceiling smoke barriers were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 30 residents who use the basement therapy room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 05/09/14 during a tour of the basement from 10:05 a.m. to 11:00 a.m., the ceiling of the basement fire alarm system room had two, two inch gaps around a cable bundle penetration through the ceiling, and the south wall near the door with no fire stopping material. Furthermore, the ceiling of the air handler room had four,</p>	K020025	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?All areas identified as a concern were repaired with appropriate fire rated caulking/drywall material including:a.The ceiling of the basement fire alarm system with two 2 inch gaps around a cable bundle which penetrate the ceiling was repaired by the maintenance director on 5/19/14 and verified by AIT Jay Nowlin to ensure completion.b.The ceiling of the air handler room where four 3 inch ceiling penetrations were repaired by the maintenance director on 5/19/14 and verified by Jay Nowlin AIT.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.All residents have the potential to be affected by this practice. Maintenance director was in serviced on 5/22/2014 on</p>	05/31/2014

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K020027 SS=E	<p>three inch ceiling penetrations where the fire stopping material had fallen out. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 05/09/14 at 1:55 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with</p>		<p>requirements of K025. All other smoke barrier walls were inspected to ensure no other penetrations were identified by the maintenance director on 5/20/14. Maintenance director will inspect any new construction or wiring to ensure smoke barrier protection is maintained. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. The Maintenance director will conduct random audits of smoke barrier walls through the monthly preventative maintenance program. If non-compliant areas are identified, the ED will be notified and action plan developed. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The Maintenance supervisor will insure there are no penetrations by completing the Environmental CQI audit tool weekly X4 and monthly X 6months. The CQI committee will determine the need for further review.</p>				

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	<p>19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 2 of 7 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice affects 21 residents who reside on the first floor 100 Hall and 18 residents who reside on the second floor 2 West Hall.</p> <p>Findings include:</p> <p>Based on observations on 05/09/14 during a tour of the first floor and second floor from 11:05 a.m. to 1:55 p.m. with the maintenance supervisor, the first floor 100 Hall set of smoke barrier doors and the second floor 2 West Hall set of smoke barrier doors each had a one inch gap along the latching sides of the doors with the doors in the closed position. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the</p>	K020027	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?The Smoke barrier door on 1 South was adjusted/repared on 5/21/2014 by the Maintenance director. Upon inspection by Jay Nowlin AIT the Smoke Barrier door has been repaired and now functions according to K027How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.All residents have the potential to be affected by this practice. Maintenance director was in-serviced on 5/22/2104 on the requirements of K027. All doors were inspected by Jay Nowlin AIT and Maintenance director and found to be closing and leaving no gap after repair.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.Smoke barrier door will be inspected monthly by the Maintenance Director during fire drill.How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.The Maintenance supervisor will insure doors close with no gaps by</p>	05/31/2014			

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K020062 SS=E	<p>exit conference on 05/09/14 at 1:55 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to replace 2 of over 300 sprinklers in the facility which were covered in corrosion and paint. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 20 residents who use the second floor sitting room and any resident receiving therapy in the basement.</p> <p>Findings include:</p> <p>Based on observations on 05/09/14 during a tour of the facility from 10:15</p>	K020062	<p>completing the Environmental CQI audit tool weekly X4 and monthly X 6months. The CQI committee will determine the need for further review</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?The linen room sprinkler head and the second floor sitting room sprinkler head will be removed and replaced with new heads on May 30, 2014How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.All residents have the potential to be affected by this deficient practice.The Maintenance Director was in serviced on 5/22/14 on the requirements of K062. A sprinkler head Audit was conducted by the Maintenance director on 5/22/14 to ensure compliance with K062, no other sprinkler heads were found to be out of compliance. The 2 sprinkler heads cited in the survey will be replaced on May 30, 2014.What measures will be put into place or</p>	05/31/2014	

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	a.m. to 1:55 p.m. with the maintenance supervisor, the basement linen room sprinkler was completely covered in brown corrosion and the second floor sitting room sprinkler was completely covered in brown paint. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 05/09/14 at 1:55 p.m. 3.1-19(b)		what systemic changes will be made to ensure that the deficient practice does not recur. A sprinkler head Audit was conducted by the Maintenance director on 5/22/14 to ensure compliance with K062, no other sprinkler heads were found to be out of compliance. The 2 sprinkler heads cited in the survey will be replaced on May 30, 2014.The Preventative Maintenance monthly task checklist has been revised to include inspection of sprinkler heads monthly. The maintenance supervisor will complete the inspection monthly and report findings to the ED. If non-compliance areas are identified, a plan of action will be developed.The Maintenance director will be responsible for ensuring that work completed by vendors; contractors etc. are thoroughly inspected after completion of work to ensure sprinkler heads are free of paint and debris. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The Maintenance supervisor will insure there are no penetrations by completing the Environmental CQI audit tool weekly X4 and monthly X 6months. The CQI committee will determine the need for further review		