

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155203	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/29/2015
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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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K 000 Bldg. 02	<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: 04/29/15</p> <p>Facility Number: 000110 Provider Number: 155203 AIM Number: 100271120</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 was built in 1966 and constructed with mixed construction consisting of a two and one-half inch thick concrete decks separating each floor, one hour fire rated smoke barrier walls, two fire barrier</p>	K 000	<p>Please find the enclosed plan of correction for the survey ending 4/29/15. Submission of this plan of correction does not constitute admission or agreement to the facts alleged or correction set forth on the statement of deficiencies The 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</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>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 the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 149 and had a census of 119 at the time of this survey.</p>			

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K 029 SS=E Bldg. 02	<p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except the detached laundry building and storage shed.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor doors to 2 of 5 hazardous areas, such as a fuel fire equipment rooms, were provided with self closing devices which would cause the doors to automatically close and latch into the door frames. This deficient practice could affect 22 residents who use the basement physical therapy room.</p> <p>Findings include:</p> <p>Based on observations on 04/29/15 during a tour of the basement physical therapy room with the maintenance</p>	K 029	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this practice The physical and speech therapy gas furnace room doors were inspected by the maintenance director and self enclosures were installed on 4/29/15. How will the facility identify other residents having the potential to e affected by the same deficient practice will be identified and what corrective action will be taken? All resident have the potential to be affected by this practice The maintenance director conducted an inspection of all gas furnace</p>	05/15/2015

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K 038 SS=E Bldg. 02	<p>supervisor from 9:05 a.m. to 10:40 a.m., the physical therapy gas furnace room and speech therapy gas furnace room doors each lacked self closing devices. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 04/29/15 at 1:45 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the sidewalk surface on 1 of 6 exit sidewalks was</p>	K 038	<p>rooms, storage rooms and mechanical rooms to ensure self closure intact and in working order No other areas were identified to be non compliant. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? The maintenance director was in-serviced on K029 as it relates to hazardous areas doors require self closures. The preventative maintenance checklist has been revised to include inspection of self closure devices. How will the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? The maintenance director of designee will complete the environmental safety CQI weekly for 4 weeks, monthly for 6 months and quarterly ongoing The audits will be reviewed during the CQI meeting and issues will be addressed and the above plan will be altered accordingly. If 100% compliance is not achieved an action plan will be implemented.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? A</p>	05/15/2015			

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	<p>maintained to prevent elevation changes. LSC 7.1.6.2 requires abrupt changes in elevation of the walking surface shall not exceed 1/4 inch. Changes in elevation exceeding 1/4 inch, but not exceeding 1/2 inch shall be beveled 1 to 2. Changes in elevation exceeding 1/2 inch shall be considered a change in level and shall be subject to the requirements of 7.1.7. This deficient practice could affect 32 residents who reside on the 2E Hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 04/29/15 at 12:45 p.m., the 2E Hall exit sidewalk had a four foot by six foot section of concrete sidewalk located sixteen feet from the exit door pitted with one inch depressions and heaving concrete with two inch elevation changes along the broken sidewalk surface. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 04/29/15 at 1:45 p.m.</p> <p>3.1-19(b)</p>		<p>contractor was hired to repair the sidewalk at the 2 East exit. How will the facility identify other residents having the potential to e affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by this practice. All sidewalks were evaluated by the maintenance director on 4/29/15 for damage and no other problem areas were identified. The Maintenance director was in-serviced regarding K038 requirements related to sidewalk elevation. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? The preventative maintenance checklist will be revised to include evaluation of sidewalks monthly. How will the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?How will the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? The maintenance director of designee will complete the environmental safety CQI weekly for 4 weeks, monthly for 6 months and quarterly ongoing .The audits will be reviewed during the CQI meeting and issues will be addressed and the above plan will be altered</p>		

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K 045 SS=E Bldg. 02	<p>NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>Based on observation and interview, the facility failed to ensure the lighting for 2 of 10 exit means of egress were arranged so the failure of any single lighting fixture (bulb) would not leave the areas in darkness. This deficient practice could affect 32 residents who reside on the 2E Hall and does not affect any residents on the unoccupied 2W Hall.</p> <p>Findings include:</p> <p>Based on observations on 04/29/15 during a tour of the 2E Hall and 2W Hall from 12:10 p.m. to 1:20 p.m., the 2E Hall and 2W Hall outside exits were provided with a single lighting fixture outside each exit door. Based on an interview with the maintenance supervisor on 04/29/15 at 1:15 p.m., the outside exit light fixtures are on emergency power. The fixtures were replaced last year during a renovation project and the dual light fixtures were replaced with single light</p>			K 045	<p>accordingly. If 100% compliance is not achieved an action plan will be implemented.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The single lighting fixture at the 2East and 2 West exits were replaced with a dual light fixtures How will the facility identify other residents having the potential to e affected by the same deficient practice will be identified and what corrective action will be taken? All resident have the potential to be affected by this practice An audit was conducted of all outside fixtures to ensure dual lighting existed at each exit. No other problem areas were identified. The maintenance director was inserviced on the requirements of K045 as it relates to dual lighting illumination at means of egress. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? The preventative maintenance checklist will be revised to include monthly checks of appropriate illumination of egress lighting.</p>		05/15/2015

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	<p>fixtures. The lack of dual lighting fixtures on emergency power along the exterior sidewalks at the 2E Hall exit and 2W Hall exit was verified by the maintenance supervisor at the time of observations and interview and acknowledged by the administrator at the exit conference on 04/29/15 at 1:45 p.m.</p> <p>3.1-19(b)</p>		<p>How will the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?How will the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? The maintenance director of designee will complete the environmental safety CQI weekly for 4 weeks, monthly for 6 months and quarterly ongoing The audits will be reviewed during the CQI meeting and issues will be addressed and the above plan will be altered accordingly. If 100% compliance is not achieved an action plan will be implemented.</p>		