STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G216	A. BUILDING -- B. WING	11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HILLCROFT SERVICES INC	423 E BERKLEY AVE MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 11/22/21 Facility Number: 000742 Provider Number: 15G216 AIM Number: 100248890 At this Emergency Preparedness survey, Hillcroft Services Inc. was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475 The facility has 6 certified beds. All 6 beds are certified for Medicaid. At the time of the survey, the census was 4. Quality Review completed on 11/29/21	E 0000		
E 0035 Bldg. --	483.475(c)(8), 483.73(c)(8) LTC and ICF/IID Sharing Plan with Patients §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an			

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. Based on record review and interview, the facility failed to ensure the emergency preparedness plan (EPP) includes a method for sharing information from the emergency plan that the facility has determined is appropriate with clients and their families or representatives in accordance with 42 CFR 483.475(c)(8). This deficient practice could affect all occupants. Findings include: Based on review of the facility's EPP with the Maintenance Specialist and Chief Operating Officer on 11/22/21 between 12:20 p.m. to 1:20 p.m., the plan provided did not address a method for sharing information with clients and their families. Based on interview at the time of records review, the Chief Operating Officer agreed the aforementioned policy was not in the provided EPP. This finding was acknowledged at the time of discovery and again at the exit conference at 2:20 p.m.	E 0035	Hillcroft Emergency Preparedness Plan communication plan will be updated to include method for sharing information from the emergency preparedness plan with clients and their families or representatives by 12/22/2021. All Clients and their families or representatives will be notified of Hillcroft's method for sharing information from the emergency preparedness plan and their access by 12/22/2021.	12/22/2021
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j).	K 0000		

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	Survey Date: 11/22/21 Facility Number: 000742 Provider Number: 15G216 AIM Number: 100248890 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 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one-story facility was fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, common living areas and hard-wired smoke detectors in all client sleeping rooms and heat detection the attic. The facility has a capacity of 6 and had a census of 4 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 1.34. Quality Review completed on 11/29/21			
K S100 Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or			

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	NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 7 of 9 cylinders in oxygen storage room of nonflammable gases such as oxygen were properly chained or supported in a proper cylinder stand or cart. LSC 33. 1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.4 requires any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature requiring periodic testing, inspection, or operation to ensure its maintenance shall be tested, inspected, or operated as specified in applicable NFPA standards. NFPA 99, 2012 Edition, Health Care Facilities Code, 11.6.2.3(11) requires freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. Findings include: Based on observation and interview during a tour of the facility with the Maintenance Specialist and Chief Operating Officer on 11/22/21 between 1:20 p.m. and 2:15 p.m., the oxygen storage room had 9 oxygen cylinders 7 of the 9 were lying unsupported on the floor. Based on interview at the time of observation, the Maintenance Specialist and Chief Operating Officer acknowledged the oxygen cylinders being unsupported in the closet. This was acknowledged by the Maintenance Specialist and Chief Operating Officer at the time of observation and again at the exit conference at 2:20 p.m.	K S100	Oxygen cylinders are not needed by any individual currently residing in the facility. All cylinders will be removed from the home by 12/22/2021. Hillcroft will develop a procedure for future oxygen cylinder storage to ensure any future oxygen cylinders are properly chained or supported in a proper cylinder stand or cart by 12/22/2021.	12/22/2021
K S222 Bldg. 01	NFPA 101 Egress Doors Egress Doors			

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	2012 EXISTING (Prompt) Doors and paths of travel to a means of escape shall not be less than 28 inches. Bathroom doors shall not be less than 24 inches. Doors are swinging or sliding. Every closet door latch shall be readily opened from the inside in case of an emergency. Every bathroom door shall be designed to allow opening from the outside during an emergency when locked. No door in any means of escape shall be locked against egress when the building is occupied. Delayed egress locks complying with 7.2.1.6.1 shall be permitted on exterior doors only. Access-controlled egress locks complying with 7.2.1.6.2 shall be permitted. Forces to open doors shall comply with 7.2.1.4.5. Door-latching devices shall comply with 7.2.1.5.10. Corridor doors are provided with positive latching hardware, and roller latches are prohibited. Door assemblies for which the door leaf is required to swing in the direction of egress travel shall be inspected and tested not less than annually in accordance with 7.2.1.15. 33.2.2.5.1 through 33.2.2.5.7, 33.7.7, 42 CFR 483.470(j)(1)(ii)			
	Based on observation and interview, the facility failed to ensure 1 of 4 exterior exit doors were provided with only one latching mechanism to release the door and open. 33.2.2.5.7 refers to 7.2.1.5.10 which states a latch or other fastening device on a door leaf shall be provided with a releasing device that has an obvious method of operation and that is readily operated under all lighting conditions. 7.2.1.5.10.4 states the releasing mechanism shall open the door leaf with not more than one releasing operation. 7.2.1.5.10.1 states the releasing mechanism for any latch shall	K S222	Door has been updated to only have one latching mechanism 12/3/2021 All exit doors were assessed and have only one latching mechanism to release the door and open.	12/03/2021

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	be located not less than 34 inches, and not more than 48 inches, above the finished floor. This deficient practice could affect all occupants in the facility. Findings include: Based on observation and interview during a tour of the facility with the Maintenance Specialist and Chief Operating Officer on 11/22/21 between 1:20 p.m. and 2:15 p.m., the Front door in the was equipped with two latching devices, a regular door handle with a turn lock and a separate sliding bolt action lock. This was acknowledged by the Maintenance Specialist and Chief Operating Officer at the time of observation and again at the exit conference at 2:20 p.m.			
K S363 Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors shall meet all of the following requirements: 1. Doors shall be provided with latches or other mechanisms suitable for keeping the door closed. 2. No doors shall be arranged to prevent the occupant from closing the door. 3. Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 in buildings other than those protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5. Door assemblies with leaves required to swing in the direction of egress travel are inspected and tested annually per 7.2.1.15. 33.2.3.6.4, 33.7.7 Based on observation and interview, the facility failed to ensure 1 of 4 clients sleeping rooms were provided with a door which would latch securely	K S363	Hillcroft Maintenance Specialist made modifications to the effected door on 12/9/2021. The door now	12/10/2021

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	in the door frame. This deficient practice could affect 2 clients. Findings include: Based on observation and interview during a tour of the facility with the Maintenance Specialist and Chief Operating Officer on 11/22/21 between 1:20 p.m. and 2:15 p.m., sleeping room corridor door described as the "side Master sleeping room did not latch into the frame due to the jamb side of the door frame being broken and missing the latching hardware. Based on interview at the time of observation, the Maintenance Specialist and Chief Operating Officer confirmed the aforementioned door failed to latch into the frame. This was acknowledged by the Maintenance Specialist and Chief Operating Officer at the time of observation and again at the exit conference at 2:20 p.m.		moves freely and securely latches in the door frame. Annually Maintenance Specialist will assess all doors in the facility move freely and latch securely and meet standards for closure.	