DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/06/2025 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER HILLOREST VILLAGE SIMMARY STATEMENT OF DEFICIENCIES SAFETRADORESS, CITY, STATE, ZIP CODE 203 SPARKS AVE JEFFERSONVILLE, IN 47130 (EACH DEPRICINATIVE OF DEFICIENCIES PRECEDED BY FULL REGULATORY OR US IDENTIFYING INFORMATION) INITIAL COMMENTS (F 000) INITIAL COMMENTS (F 000) INITIAL COMMENTS This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaint IN004596231 completed on 5/2/25. This visit was for onjunction with the Investigation of Complaint IN00459699. Complaint IN00459509 - No deficiencies related to the allegation is cited. Survey dates: May 28 and 29, 2025 Facility number: 0002110 Provider number: 15203 All number: 100271120 Census Bed Type: SNF: 15 Total: 120 Census Payor Type: Medicare: 10 Medica	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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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.

Facility ID: 000110