STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155203	A. BUILDING 00 B. WING	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HILLCREST VILLAGE	203 SPARKS AVE JEFFERSONVILLE, IN 47130

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00436365 and IN00437950. Complaint IN00436365 - Federal/State deficiencies related to the allegations are cited at F609 and F684. Complaint IN00437950 - No deficiencies related to the allegation is cited. Survey dates: July 19, 22 and 23, 2024 Facility number: 000110 Provider number: 155203 AIM number: 100271120 Census Bed Type: SNF/NF: 104 SNF: 15 Total: 119 Census Payor Type: Medicare: 16 Medicaid: 70 Other: 33 Total: 119 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 30, 2024.	F 0000	/p> This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after (8/12/24)	
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations Based on interview and record review, the facility management failed to report an incident to the	F 0609	**F – 609 – Reporting of Alleged Violations**	08/12/2024

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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	Indiana Department of Health when a resident (Resident B) reported an allegation of abuse for 1 of 3 residents reviewed for verbal abuse. Findings include: The clinical record for Resident B was reviewed on 7/22/24 at 9:33 a.m. The diagnoses included, but were not limited to, right fibula/tibia fracture and peripheral autonomic neuropathy. The Admission MDS (minimum data set) assessment, dated 5/7/24, indicated the resident's cognition was alert and oriented. During a telephone interview on 7/22/24 at 9:59 a.m., Resident B indicated she had multiple bad interactions with LPN (Licensed Practical Nurse) 7. During one incident, she had requested her pain medication from LPN 7, at which point, LPN 7 became aggressive and told Resident B she had a "problem". Resident B asked LPN 7 why she had to be such a "smart a**" and LPN 7 responded "because you are acting like a smart a**". She reported the incident to LPN 6. Review of the facility reported incidents for June 2024 lacked documentation of an allegation of verbal abuse for Resident B. During an interview on 7/23/24 at 11:16 a.m., LPN 6 indicated Resident B did report that LPN 7 called her a "smart a**". She reported the incident to the ED (Executive Director). During an interview on 7/23/24 at 11:32 a.m., the ED indicated no staff member had reported anything of that nature to him. The facility provided no other information related		**1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** The allegation regarding resident B was immediately reported to ISDH and APS and an investigation was initiated. Resident B returned home on 7/1/24 and LPN 6 was suspending pending investigation. **2: How other residents having the potential to be 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 the alleged deficient practice. On 7/24/24, ED/designee began in-servicing all staff on the facility's abuse prohibition, prevention, and reporting policy and the zero-tolerance position of the facility. All interview able residents who were provided care by LPN 6 were interviewed using abuse/neglect questions, no concerns were identified. All Staff who worked with LPN 6 were interviewed using staff questionnaires, results of questions resulted with no concerns. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**	

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	to the incident. On 7/23/24 at 1:06 p.m., the Director of Nursing provided a current copy of the document titled "Abuse Prohibition, Reporting, and Investigation dated 6/2023. It included, but was not limited to, "Reporting/Response...All abuse allegations must be reported to the Executive Director immediately...it must be reported immediately but no later than 2 hours to the Long-Term Care Division of the Indiana Department of Health via the Gateway Portal...." This Citation relates to Complaint IN00436365. 3-1.28(c)		On 8/5/24 DNS /designee began completing an Abuse-Staff Interview QAPI tool to ensure on going and continued education regarding abuse prohibition, prevention, and reporting. Any staff members that do not answer the interviews correctly will receive additional education and any concerns noted will be reported in accordance with facility policy. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** The DNS /designee will be responsible for the Abuse – Staff Interview audit tool weekly times 4 weeks, monthly times 6, then quarterly thereafter until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI Committed overseen by the ED. If a threshold of 90% is not achieved, an action plan will be developed. **5.** Date of compliance: 8/12/24	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to ensure a resident's blood pressure was obtained prior to medication administration (Resident D) for 1 of 3 residents reviewed for quality of care.	F 0684	**F - 684: Quality of Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	08/12/2024

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	Findings include: The clinical record for Resident D was reviewed on 7/22/24 at 12:40 p.m. The diagnoses included, but were not limited to, cardiovascular disease and hypertension (high blood pressure). The physician's order, dated 5/22/24, indicated the resident was to receive Clonidine HCl (hydrochloride) 0.1 mg (milligrams) every 6 hours at 12:00 a.m., 6:00 a.m., 12:00 p.m. and 6:00 p.m. for hypertension. The medication was to be held for a systolic blood pressure less than 100. The care plan, dated 5/5/2021, indicated the resident was at risk for ineffective tissue perfusion due to hypertension and to administer medications as ordered by the physician. Review of the June and July 2024 MAR (medication administration record) indicated the following related to the administration of Resident D's Clonidine: - On 6/02/24 at 6:00 a.m., the resident's Clonidine was administered. The resident's blood pressure was not documented. - On 6/02/24 at 12:00 p.m., the resident's Clonidine was administered. The resident's blood pressure was not documented. - On 6/02/24 at 6:00 p.m., the resident's Clonidine was administered. The resident's blood pressure was not documented. - On 6/08/24 at 12:00 a.m., the resident's Cloniidine was not administered as it was on hold. There was no documentation as to why the medication was on hold. During an interview on 7/23/24 at 1:43 p.m., LPN (Licensed Practical Nurse) 8 indicated if there were		**practice:** Resident D medication order was reviewed, parameters verified, and vital history reviewed from 6/2/24 through 6/9/24, residents' medications continue as ordered. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents with clonidine orders have the potential to be affected by the alleged deficient practice. On 7/24/24, DNS / Designee completed an audit of residents ordered clonidine to ensure Blood Pressures Parameters were in place and documented as ordered. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** On 7/24/24, CEN began servicing all licensed staff on Blood Pressure Parameters and documentation requirements. On 7/24/24, DNS/designee began every shift audit to ensure documentation of blood pressure parameters for all residents with clonidine orders. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	blood pressure parameters in place for a resident, the resident's blood pressure should have been documented and obtained prior to the administration of the medication. On 7/23/24 at 1:06 p.m., the Director of Nursing provided a current copy of the document titled "Medication Administration (Medication Pass Procedure) dated 7/23. It included, but was not limited to, "Vital signs obtained, if necessary...Medication administration will be recorded on the MAR...after given...." This Citation relates to Complaint IN00436365. 3.1-37		**assurance program will be put into place.** DNS / Designee will be responsible for every shift audit related to Blood Pressure Parameters weekly for 4 weeks, then monthly for 6 months or until 100% compliance is achieved. The results of these audits will be reported to the facility QAPI Committee monthly. If 90% compliance is not achieved an action plan will be developed. **By what date the systemic changes for each deficiency will be completed.** Systemic changes will be completed 8/12/24.	