STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155203	A. BUILDING -- B. WING	01/17/2024

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

(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 483.73. Survey Date: 01/17/24 Facility Number: 000110 Provider Number: 155203 AIM Number: 100271120 At this Emergency Preparedness survey, Hillcrest Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 149 certified beds. At the time of the survey, the census was 116. Quality Review completed on 01/24/24	E 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 (2/29/24)	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/17/24 Facility Number: 000110 Provider Number: 155203 AIM Number: 100271120 At this Life Safety Code survey, Hillcrest Village was found not in compliance with Requirements	K 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 (2/29/24)	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mark Bowman	Executive Director	02/05/2024

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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	for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. Hillcrest Village is a three story building. 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 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 physical therapy area 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. The facility is fully sprinklered. The facility has a fire alarm system with smoke detection on all levels including the corridors, spaces open to the corridors, and has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 149 and had a census of 116 at the time of this survey.			

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	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. Quality Review completed on 01/24/24			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 2 of 13 cross-corridor door sets would self close and latch into the door frame per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:55 p.m. to 4:45 p.m. on 01/17/24, the north door in the cross-corridor door set by Room 125 was held in the fully open position with a magnetic hold open device set to release with fire alarm system activation, latching hardware and a self closing device but the door failed to self close and latch into the door frame when tested to close multiple times. In addition, the north door in the cross-corridor door set by the Central Supply	K 0100	**K-100 – General Requirements - Other** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents, staff or visitors were affected by the alleged deficient practice. **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?** 20 residents, staff and visitors could have the potential to be affected by the alleged deficient	02/29/2024

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	Room by Room 214 was also held in the fully open position with a magnetic hold open device set to release with fire alarm system activation, latching hardware and a self closing device but the door failed to self close and latch into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Maintenance Supervisor agreed the doors in the aforementioned cross-corridor door sets would not fully self close and latch into the door frame when tested to close. These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference. 3.1-19(b)		practice during an emergency related to a fire. On 1/18/24, the Maintenance Director inspected the cross-corridor doors by room 125 and room 214. Both doors self-closed but failed to latch. Adjustments were made without successful latching. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur?** On 1/18/24, Maintenance staff was educated on K-100 General Requirments of LSC section 4.6.12.3 related to the self-closure and positive latching on all cross-corridor doors. ED and Maintenance Director audited all cross-corridor doors to ensure self-closure and positive latching on all 13 cross-corridor doors using a K-100 LSC audit tool. All doors self-closed and 2 of the 13 failed to positively latch. On 1/19/24, Maintenance director contacted vendor to perform repairs on the 2 affected doors, service scheduled for 2/6/24 for repairs / replacement. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?**	

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			The Maintenance Director or designee will be responsible for the completion of the K-100 LSC audit to ensure that all 13 cross-corridor doors self-close and positively latch into the door frame. The audits will be completed weekly times 4 weeks, monthly times 6 months and semiannually thereafter to ensure compliance. The results of the audits will be reviewed monthly by the QAPI committee overseen by the Administrator. Any areas noted to be non-compliant with the audits will be corrected. All systemic changes will be completed by 2/29/24.	
K 0161 SS=F Bldg. 01	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered			

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	3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. Based on observation and interview, the facility failed to maintain the limited noncombustible rating in accordance with LSC Table 19.1.6.1. This deficient practice could affect all occupants. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:55 p.m. to 4:45 p.m. on 01/17/24, unprotected structural steel i-beams were noted as interior load bearing structural supports in the wheel chair storage room on the ground floor near the main entrance for the facility on the south side of the building. The room also contained natural gas fired furnaces. Based on interview at the time of the observations, the Maintenance Supervisor stated this portion of the facility was three stories	K 0161	**K-161 – Building Construction** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents, staff or visitors were affected by the alleged deficient practice. **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?**	02/29/2024

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	in height and agreed unprotected structural steel i-beams were noted as load bearing structural supports in the wheel chair storage room on the ground floor. These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference. 3.1-19(b)		All residents, staff and visitors could have the potential to be affected by the alleged deficient practice during an emergency related to a fire. On 1/29/24, the Maintenance Director contacted a vendor to determine scope and cost related to encapsulating the exposed I Beams noted in the wheelchair storage room. Vendor scheduled for 2/6/24 to provide quote. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur?** On 1/29/24, Maintenance staff was educated on K-161 Building Construction LSC section 19.1.6.1 /whereas exposed load bearing structural steel I beams must be encapsulated with an appropriate fire rated material. ED and Maintenance Director inspected all areas of the facility, to ensure to identify any other areas with exposed structural steel I beams. The wheelchair storage room was the only area noted to have exposed structural steel I beams. A vendor has been scheduled for 2/6/24 to determine scope and cost of work to encapsulate the I beams with an appropriate fire rated material. Facility intends to update the the facility to meet this requirement by 2/29/24.	

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			Additionally, the wheelchair storage room is fully protected by the sprinkler system and as an added measure the facility added an additional fire extinguisher to this area on 1/29/24. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** The Maintenance Director or designee will be responsible for the completion of the K-1 LSC audit to ensure that all exposed load bearing structural steel I -beams are encapsulated by an appropriate fire rated material. The audits will be completed weekly times 4 weeks, monthly times 6 months and semiannually thereafter to ensure compliance. The results of the audits will be reviewed monthly by the QAPI committee overseen by the Administrator. Any areas noted to be non-compliant with the audits will be corrected. All systemic changes will be completed by 2/29/24.	
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that			

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	requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by			

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	an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 4 of 4 stairwell exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. LSC Section 7.2.1.5.3 states locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:55	K 0222	**K-222 – Egress Doors** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents, staff or visitors were affected by the alleged deficient practice. **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, staff and visitors could have the potential to be	02/16/2024

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	p.m. to 4:45 p.m. on 01/17/24, the stairwell exit door by Room 140, by Room 319, by the 2 South Nurse's Station and by the Moving Forward Nurse's Station were each marked as a facility exit with an exit sign. Each stairwell door could be released to open by entering a code at a keypad at the stairwell exit door but each keypad was posted with the following keypad code notes "*Our Building Number". Based on interview at the time of observations, the Maintenance Supervisor agreed the building number would not be known to everyone that enters the building that does not have a clinical diagnosis requiring specialized security measures to actuate the door release. The Maintenance Supervisor was able to open the doors with the "*Our Building Number" code. These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference. 3.1-19(b)		affected by the alleged deficient practice during an emergency not related to fire or loss of power. On 1/18/24, the Maintenance Director changed all stairwell exit door codes and added new hint signs to match the code. The hint provided is of common knowledge, “last digit of next month and last 2 digits of 5 years from now = door code. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur?** On 1/18/24, Maintenance staff was educated on egress door requirements of LSC section 19.2.2.2.5.2 and a K-222 life safety compliance audit tool for egress doors whereas all egress doors shall have a code hint posted and that code hint shall be a hint that could be known by anyone that enters the facility, the hint must match the code to enter / exit the facility. On 1/18/24, a life safety compliance audit on egress doors was performed by the Administrator and Maintenance Director using the egress door audit tool, all areas met compliance standards as they all provide a hint sign that could be known by anyone that enters the facility.	

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			How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place? The Maintenance Director or designee will be responsible for the completion of the life safety compliance audit of egress doors. The audits will be completed weekly times 4 weeks, monthly times 6 months and semiannually thereafter to ensure compliance. The results of the audits will be reviewed monthly by the QAPI committee overseen by the Administrator. Any areas noted to be non-compliant with the audits will be corrected. All systemic changes will be completed by 2/16/24	
K 0311 SS=E Bldg. 01	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING 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 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box.			

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	Based on observation and interview, the facility failed to maintain protection of 1 of 5 interior stairwells. LSC 19.3.1 requires vertical openings shall be enclosed or protected in accordance with Section 8.6. LSC 8.6.1 requires every floor that separates stories in a building shall be constructed as a smoke barrier. LSC 8.6.5 states see 7.1.3.2.1 for enclosures of exits. LSC 7.1.3.2.1 states the separation shall have a minimum 1-hr fire resistance rating where the exit connects three stories or less. Existing penetrations shall be protected in accordance with 8.3.5. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the 1 West Nurse's Station. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:55 p.m. to 4:45 p.m. on 01/17/24, the stairwell door by the Mechanical Room by the 1 West Nurse's Station was equipped with a self closing device and a latching mechanism on the stairwell door but the door failed to latch into the door frame when tested to close multiple times. The latching mechanism on the door was "dogged down". The stairwell door was equipped with a 90 minute fire resistance rating label. Based on interview at the time of the observations, the Maintenance Supervisor agreed the aforementioned stairwell door failed to latch into the door frame to enclose the vertical opening with a minimum 1-hour fire resistance rating. These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference. 3.1-19(b)	K 0311	**K-311 – Vertical Openings** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents, staff or visitors were affected by the alleged deficient practice. **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?** 20 residents, staff and visitors could have the potential to be affected by the alleged deficient practice during an emergency related to a fire. On 1/18/24, Maintenance Director inspected the stairwell door by the mechanical room by 1 west nurses' station. Adjustments made without success. A vendor was contacted, and repairs are scheduled for 2/6/24. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur?** On 1/18/24, Maintenance staff was educated on K-311 Vertical Openings related to LSC section	02/29/2024

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			19.3.1 and a K-311 life safety compliance audit tool for vertical openings. On 1/18/24, a life safety compliance audit on vertical openings was performed by the Administrator and Maintenance Director using the K-311 Vertical openings audit tool, 1 of 5 area's did not meet compliance standards, vendor scheduled for 2/6/24 to perform repairs. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** The Maintenance Director/Designee will be responsible for the completion of the K-311 Vertical openings Audit tools. The audits will be completed weekly times 4 weeks, monthly times 6 months and semiannually thereafter to ensure compliance. The results of the audits will be reviewed monthly by the QAPI committee overseen by the Administrator. Any areas noted to be non-compliant with the audits will be corrected. All systemic changes will be completed by 2/29/24	
K 0321 SS=E	NFPA 101 Hazardous Areas - Enclosure			

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Bldg. 01	Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of over 21 hazardous areas such as fuel fired heater rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 5 residents, staff and	K 0321	**K-321 – Hazardous Areas - Enclosure** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	02/16/2024

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	visitors on the ground floor near the main entrance of the facility on the south side of the building. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:55 p.m. to 4:45 p.m. on 01/17/24, several holes were noted in the ceiling of the wheel chair storage room on the ground floor near the main entrance for the facility on the south side of the building. The room contained natural gas fired furnaces. Based on interview at the time of the observations, the Maintenance Supervisor agreed the aforementioned openings in the wheel chair storage room ceiling did not separate this hazardous area from other spaces with smoke resistant partitions. These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference. 3.1-19(b)		No residents, staff or visitors were affected by the alleged deficient practice. **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?** 5 residents, staff and visitors could potentially be affected by the alleged deficient practice during an event related to fire. This area is only used for storage, only authorized staff have access. On 1/30/24, the Maintenance Director assessed all 41 storage areas for unsealed wall penetrations, 1 of 41 noted, all penetrations sealed using fire caulk. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur?** On 1/30/24, Maintenance staff was educated on the hazardous area's LSC section 19.3.5.9 and 19.3.2.1 a life safety compliance audit tool for "Hazardous Areas" whereas all wall and ceiling penetrations must be patched / Sealed with fire caulk. On 1/30/24, The life safety compliance audit for hazardous areas was performed by the	

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			Administrator and Maintenance Director, all storage rooms audited and met compliance related to wall and ceiling penetrations. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** The Maintenance Director or designee will be responsible for the completion of the life safety compliance audits of hazardous areas. The audits will be completed weekly times 4 weeks, monthly times 6 months and semiannually thereafter to ensure continued compliance. The results of the audits will be reviewed monthly by the QAPI committee overseen by the Administrator. Any areas noted to be non-compliant with the audits will be corrected. All systemic changes will be completed by 2/16/24	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler			

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	Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to maintain the ceiling construction for 1 of 3 ceilings in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect over 10 residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:55 p.m. to 4:45 p.m. on 01/17/24, gaps and cracks were noted in escutcheons for ceiling mounted sprinklers in the following areas: a. in Room 120. b. in the Laundry Services Room by the 1 West Nurse's Station. c. in the bathroom in the West Dining Room. Based on interview at the time of the observations, the Maintenance Supervisor agreed the escutcheons for the aforementioned sprinkler	K 0351	**K-351 – Sprinkler System - Installation** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. **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?** 10 residents, staff and visitors have the potential to be affected by the alleged deficient practice during an emergency related to a fire. On 1/22/24, maintenance director adjusted the escutcheons in room 120, Landry services	02/16/2024

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	locations each had gaps and cracks which did not maintain the ceiling construction. These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference. 3.1-19(b)		Room by 1 west nurses' station and the bathroom in the west dining room to eliminate gapping. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur?** On 1/22/24, Maintenance staff was educated on NFPA 13 section 6.2.7.1 to ensure that all escutcheons were properly secured to the sprinkler head and no gapping should be present. On 1/22/24, Maintenance Director and Administrator audited all sprinkler heads to ensure that all escutcheons were properly secured using a sprinkler head audit tool. Any escutcheons noted to be out of compliance were immediately adjusted to eliminate gapping to meet code standards. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** The Maintenance Director or designee will be responsible for the completion of the Sprinkler Head Audits. The audits will be completed weekly times 4 weeks, monthly times 6 months and	

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			semiannually thereafter to ensure continued compliance. The results of the audits will be reviewed monthly by the QAPI committee overseen by the Administrator. Any areas noted to be non-compliant with the audits will be corrected. All systemic changes will be completed by 2/16/24	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility failed to maintain 1 of 3 sprinkler systems in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 edition, Section 5.2.2.2 states sprinkler piping shall	K 0353	**K-353 – Sprinkler System – Maintenance and Testing** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	02/16/2024

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	not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect over 30 residents, staff and visitors in the vicinity of the Utility Room across from the 1 West Nurse's Station and in the vicinity of Room 325. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:55 p.m. to 4:45 p.m. on 01/17/24, bundled cables were resting on horizontal sprinkler piping in the Utility Room across from the 1 West Nurse's Station. In addition, two blue cables were affixed with cable ties to horizontal sprinkler piping in the attic as observed from the attic access door near the corridor door set by Room 325. Based on interview at the time of the observations, the Maintenance Supervisor agreed the aforementioned sprinkler pipe locations were used to support non-system components. These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 ground floor Therapy Rooms. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of		**practice?** No residents, staff or visitors were affected by the alleged deficient practice. **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?** 30 residents, staff and visitors could be affected by the alleged deficient practice during an event related to fire. On 1/18/24, maintenance director removed the data lines that were secured to the sprinkler piping in the utility room across from the 1 west nurses' station and the wires noted to be attached to the sprinkler line in the attic by room 325. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur?** On 1/23/24, Maintenance staff was educated on the standards for inspection, testing and maintenance of the fire protection systems related to NFPA 25 5.2.2.2 whereas nothing can be secured to and or obstructing sprinkler piping. On 1/23/24 a K-353 sprinkler system audit was performed by the Maintenance	

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	sprinkler and the type of construction. This deficient practice could affect over 5 residents, staff, and visitors in the Therapy Room on the ground floor. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:55 p.m. to 4:45 p.m. on 01/17/24, the annular space surrounding three electrical conduits which penetrated a suspended ceiling tile above the former wall mounted piped gas station outlets in the Therapy Room on the ground floor was not firestopped to maintain the ceiling construction in the room. Based on interview at the time of the observations, the Maintenance Supervisor agreed the aforementioned opening in the ceiling of the Therapy Room did not maintain the ceiling construction for the room. These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference. 3.1-19(b)		Director and the Administrator to assess all areas of the facility for wires and or items attached to the sprinkler lines, all areas met compliance standards. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** The Maintenance Director or designee will be responsible for the completion of the life safety compliance audits of the sprinkler system. The audits will be completed weekly times 4 weeks, monthly times 6 months and semiannually thereafter to ensure continued compliance. The results of the audits will be reviewed monthly by the QAPI committee overseen by the Administrator. Any areas noted to be non-compliant with the audits will be corrected. All systemic changes will be completed by 2/16/24	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment			

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	(PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 3 of 3 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of	K 0920	**K - 920 –Electrical Equipment – Power Cords and Extensions** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents, staff or visitors were affected by the alleged deficient practice. On 1/24/24 the bed and nebulizer machine in room 140 was unplugged from the power strip and plugged directly into the wall. The bed and refrigerator in room 302 were also unplugged from the power strip and plugged directly into the wall. The nebulizer machine in room 311 was also unplugged from the	02/16/2024

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	patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect over 10 residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:55 p.m. to 4:45 p.m. on 01/17/24, the resident bed, an oxygen mask machine and a charging cable for a vaporizer smoking device were plugged into a power strip which was affixed to a night stand one foot from the resident bed in Room 140. The resident bed, a refrigerator and two cell phone charging cables were plugged into a power strip which was affixed to a night stand one foot from the resident bed in Room 302. An oxygen mask machine, a radio and a cell phone charging cable were plugged into a power strip which was affixed to a night stand one foot from the resident bed in Room 311. The UL listing of each of the three power strips was 1363A. Based on interview at the time of the observations, the Maintenance Supervisor agreed a power strip was being used in the patient care vicinity for PCREE and non-PCREE and as a substitute for fixed wiring at the aforementioned three locations in the facility. These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference.		power strip and plugged directly into the wall. **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?** 10 residents, staff and visitors could have the potential to be affected by the alleged deficient practice in the event of a power strip failure. On 1/24/24 the Maintenance Director and Administrator inspected each resident room to ensure NFPA 101 requirments for electrical equipment to ensure proper application, type and use of power strips. Any items found to be out of compliance were adjusted to me meet compliance standards. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur?** On 1/24/24, Maintenance staff was educated on the appropriate use of power strips in patient care areas that meet “hospital grade” approved UL standards and NFPA 101 requirments for electrical equipment. A life safety compliance audit was performed to determine proper application,	

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	3.1-19(b)		type and use of power strips. On 1/24/24, No new issues were identified, and all affected areas identified during survey have been corrected. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** The Maintenance Director or designee will be responsible for the completion of the life safety compliance audit on proper application, type and use of power strips. The audits will be completed weekly times 4 weeks, monthly times 6 months and semiannually thereafter to ensure compliance. The results of the audits will be reviewed monthly by the QAPI committee overseen by the Administrator. Any areas noted to be non-compliant with the audits will be corrected. All systemic changes will be completed by 2/16/24	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed,			

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	155203	A. BUILDING 01 B. WING	01/17/2024

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HILLCREST VILLAGE	203 SPARKS AVE JEFFERSONVILLE, IN 47130

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	and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 1 of 1 indoor oxygen storage locations was provided with a precautionary sign	K 0923	**K - 923 –Gas Equipment – Cylinder and Container Storage**	02/16/2024

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	indicating that smoking in the immediate area is not permitted. NFPA 99 Health Care Facilities Code, 2012 Edition, Section 11.3.4 states oxygen cylinder and storage locations shall be provided with a precautionary sign readable from a distance of 5 feet shall be posted on each door or gate of the storage room or enclosure. Section 11.3.4.2 states the sign shall include following wording as a minimum: "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room by the Laundry Services room across from Room 319. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:55 p.m. to 4:45 p.m. on 01/17/24, the oxygen storage/transfilling room by the Laundry Services room across from Room 319 was not provided with the necessary signage prohibiting smoking in the immediate area. Eleven liquid oxygen containers and 22 'E' type oxygen cylinders were observed stored in the room. Based on interview at the time of the observations, the Maintenance Supervisor agreed the oxygen storage/transfilling room across from Room 319 was not provided with the necessary signage prohibiting smoking. These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference. 3.1-19(b)		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents, staff or visitors were affected by the alleged deficient practice. **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?** 10 residents, staff and visitors could have the potential to be affected by the alleged deficient practice in the event of a fire emergency. On 1/18/24 a precautionary sign “No Smoking O2 in use” was secured to the door frame of the only facility O2 storage area across from room 319. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur?** On 1/18/24, Maintenance staff was educated on NFPA 99 section 11.3.4 whereas oxygen cylinder and storage locations shall be provided with a precautionary sign readable from a	

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			distance of 5 feet shall be posted on the door. On 1/18/24, a life safety compliance audit for precautionary signage “No Smoking O2 in use” in place on Oxygen storage room door was performed by the ED and Maintenance director. The sign was observed in place on the Oxygen storage room door. No new issues were identified, and the affected area identified during survey has been corrected. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** The Maintenance Director or designee will be responsible for the completion of the life safety compliance audit on precautionary signage. The audits will be completed weekly times 4 weeks, monthly times 6 months and semiannually thereafter to ensure compliance. The results of the audits will be reviewed monthly by the QAPI committee overseen by the Administrator. Any areas noted to be non-compliant with the audits will be corrected. All systemic changes will be completed by 2/16/24	

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K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen transfilling locations was provided with a precautionary sign indicating that smoking in the immediate area is not permitted. NFPA 99 Health Care Facilities Code, 2012 Edition, Section 11.5.2.3.1(3) states the transfilling of liquid oxygen area shall be posted with a sign indicating that transfilling is occurring and that smoking in the immediate area is not permitted. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room by the Laundry Services room across from Room 319. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:55 p.m. to 4:45 p.m. on 01/17/24, the oxygen storage/transfilling room by the Laundry Services room across from Room 319 was not provided with signage indicating that smoking in the immediate area is not permitted. Eleven liquid oxygen containers and 22 'E' type oxygen	K 0927	**K - 927 –Gas Equipment – Transfilling Cylinders** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents, staff or visitors were affected by the alleged deficient practice. **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?** 10 residents, staff and visitors could have the potential to be affected by the alleged deficient practice in the event of a fire emergency. On 1/18/24 a	02/16/2024

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	cylinders were observed stored in the room. Based on interview at the time of the observations, the Maintenance Supervisor stated oxygen transfilling occurs in the room and agreed the oxygen storage/transfilling room across from Room 319 was not provided with signage indicating that smoking in the immediate area is not permitted. These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference. 3.1-19(b)		precautionary sign “No Smoking O2 in use” was secured to the door frame of the only facility O2 storage area across from room 319. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur?** On 1/18/24, Maintenance staff was educated on NFPA 99 section 11.3.4 whereas oxygen cylinder and storage locations shall be provided with a precautionary sign readable from a distance of 5 feet shall be posted on the door. On 1/18/24, a life safety compliance audit for precautionary signage “No Smoking O2 in use” in place on Oxygen storage room door was performed by the ED and Maintenance director. The sign was observed in place on the Oxygen storage room door. No new issues were identified, and the affected area identified during survey has been corrected. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?**	

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			The Maintenance Director or designee will be responsible for the completion of the life safety compliance audit on precautionary signage. The audits will be completed weekly times 4 weeks, monthly times 6 months and semiannually thereafter to ensure compliance. The results of the audits will be reviewed monthly by the QAPI committee overseen by the Administrator. Any areas noted to be non-compliant with the audits will be corrected. All systemic changes will be completed by 2/16/24	