PRINTED: 02/08/2024

	T OF HEALTH AND HU R MEDICARE & MEDIC				FORM APPROVED OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155203	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/17/2024
	PROVIDER OR SUPPLIEI	R	203 SF	ADDRESS, CITY, STATE, ZIP COD PARKS AVE ERSONVILLE, IN 47130	
(X4) ID PREFIX TAG E 0000	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
Bldg	conducted by the Ir accordance with 42 Survey Date: 01/1/ Facility Number: 0 Provider Number: 100 At this Emergency Village was found Preparedness Requ Medicaid Participa CFR 483.73. The facility has 149 the survey, the cens	7/24 000110 155203 0271120 Preparedness survey, Hillcrest in compliance with Emergency irements for Medicare and ting Providers and Suppliers, 42 9 certified beds. At the time of	E 0000	="" p=""> This provider respectfully require that this 2567 Plan of Correct be considered the Letter of Credible Allegation of Complicand requests a desk review in of a post survey review on or (2/29/24)	ion ance n lieu
K 0000 Bldg. 01	A4:2 0 0 4 G 1	Position of the state of the st			
	Licensure Survey v	000110 155203	K 0000	="" p=""> This provider respectfully required that this 2567 Plan of Correct be considered the Letter of Credible Allegation of Compliand requests a desk review in of a post survey review on or (2/29/24)	ion ance n lieu

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

At this Life Safety Code survey, Hillcrest Village was found not in compliance with Requirements

> 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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	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155203	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	COMI	E SURVEY PLETED 7/2024
	PROVIDER OR SUPPLIEF	· · · · · · · · · · · · · · · · · · ·	203 SF	ADDRESS, CITY, STATE, ZIP C PARKS AVE RSONVILLE, IN 47130	OD	_
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE PPROPRIATE	(X5) COMPLETION DATE
TAG	for Participation in Subpart 483.90(a), 2012 edition of the Association (NFPA Chapter 19, Existin 410 IAC 16.2. Hillcrest Village is building was constructed with many at two and one-half separating each flow barrier walls, two fit two hour construction walls with metal studrywall, a mix of conversation walls with one-half trusses and wooden Based on the lowest construction. The construction type was construction. The construction including the level 2 East Wing was southeast of the original form of the south length of the addition including the construction. Becauth addition are the facility was surveyed. The facility is fully fire alarm system was detectors in all residence in the sum of the	Medicare/Medicaid, 42 CFR Life Safety from Fire and the National Fire Protection) 101, Life Safety Code (LSC), g Health Care Occupancies and a three story building. The nucted at two different times. In was built in 1966 and ixed construction consisting of inch thick concrete decks or, one hour fire rated smoke ire barrier walls constructed of on on each level, brick exterior ads and one-half hour rated oncrete and metal stud interior indur rated drywall, and metal rafters in the roof assembly. It construction type, the facility ras classified as Type V (111) original building was built with indation exposed at the entire facility. In 1974, a two story the level 1 Transcare Unit and was constructed to the ginal building and the column verted into a poured finished ea and is also of Type V (111) use the original building and same type of construction, the ed as one building. sprinklered. The facility has a rith smoke detection on all corridors, spaces open to the nattery operated smoke dent sleeping rooms. The	TAG	DETGLEACT		DATE
	116 at the time of the	ity of 149 and had a census of nis survey.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155203		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING X3) DATE SURVEY COMPLETED 01/17/2024				
	PROVIDER OR SUPPLIEF		203 SF	ADDRESS, CITY, STATE, ZIP COD PARKS AVE RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
K 0100 SS=E Bldg. 01	were sprinkled and services were sprinkled and services were sprinkled and services were sprinkled and particles and the services are services were sprinkled and the services and the services are services are services are services are services and the services are ser	mpleted on 01/24/24 ments - Other RKS section any LSC 19.1 General Requirements ssed by the provided dicient. This information, plicable Life Safety Code or tation, should be included 37. on and interview, the facility f 13 cross-corridor door sets d latch into the door frame per 12.3 requires existing life safety the public if not required by dither maintained or removed. ice could affect over 20	K 0100	K-100 – General Requirement 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 waffected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice was identified and what corrective action(s) will be taken?	vere nt y	

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cross-corridor door set by the Central Supply

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affected by the alleged deficient

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155203	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 01/17/2024
	PROVIDER OR SUPPLIEF		203 SF	ADDRESS, CITY, STATE, ZIP CO PARKS AVE RSONVILLE, IN 47130	OD .
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMPLETION DATE
	Room by Room 21- position with a mag release with fire ala hardware and a self failed to self close a when tested to close interview at the tim Maintenance Super aforementioned cro not fully self close a when tested to close These findings were	4 was also held in the fully open metic hold open device set to rm system activation, latching closing device but the door and latch into the door frame e multiple times. Based on e of the observations, the visor agreed the doors in the ss-corridor door sets would and latch into the door frame e.		practice during an emer related to a fire. On 1/1 Maintenance Director in the cross-corridor doors 125 and room 214. Bot self-closed but failed to Adjustments were made successful latching. What measure will be place or what systemic changes will be made ensure that the deficie practice does not occur. On 1/18/24, Maintenance was educated on K-100 Requirments of LSC se 4.6.12.3 related to the sand positive latching on cross-corridor doors. Emaintenance Director a cross-corridor doors to self-closure and positive on all 13 cross-corridor using a K-100 LSC aud doors self-closed and 2 failed to positively latch 1/19/24, Maintenance of contacted vendor to per repairs on the 2 affected service scheduled for 2 repairs / replacement.	8/24, the aspected s by room th doors latch. e without put into c to a staff of General ction self-closure a all D and udited all ensure e latching doors it tool. All of the 13 on the control of the contr
				How the corrective act will be monitored to er deficient practice will recur, ie., what quality assurance program wi into place?	nsure the not

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	155203	A. BUILDING B. WING		
	PROVIDER OR SUPPLIER		203 SP	ADDRESS, CITY, STATE, ZIP COD ARKS AVE	
HILLCRE	ST VILLAGE		JEFFEI	RSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0161 SS=F Bldg. 01	Building Construct 2012 EXISTING Building construct Table 19.1.6.1, un 19.1.6.2 through 1 19.1.6.4, 19.1.6.5	tion Type and Height tion Type and Height ion type and stories meets less otherwise permitted by 9.1.6.7 tion Type (332), II (222) Any number non-sprinklered and One story Maximum 3 stories		The Maintenance Director or designee will be responsible for the completion of the K-100 L3 audit to ensure that all 13 cross-corridor doors self-close positively latch into the door frame. The audits will be completed weekly times 4 were monthly times 6 months and semiannually thereafter to ensure compliance. The results of the audits will be reviewed monthly the QAPI committee overseen the Administrator. Any areas noted to be non-compliant with audits will be corrected. All systemic changes will be completed by 2/29/24.	eks, sure e ly by

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sprinklered

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	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPI PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDIN 155203 B. WING		IPLE CONSTRUCTION ING <u>01</u>	COM	TE SURVEY PLETED 7/2024	
	PROVIDER OR SUPPLIES	R	20	TREET ADDRESS, CITY, STATE, ZIP O	COD	
HILLOR	EST VILLAGE		JI	EFFERSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		O PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	3 II (000) non-sprinklered 4 III (211) sprinklered 5 IV (2HH) 6 V (111) 7 III (200) non-sprinklered 8 V (000)	Not allowed Maximum 2 stories Not allowed Maximum 1 story				
	throughout by an automatic system 9.7. (See 19.3.5) Give a brief description, the basements, floors located, location of dates of approval small floor plan of Based on observatifailed to maintain trating in accordance deficient practice of the based on observation. Based on observation accordance deficient practice of the based on observation accordance deficient practice deficient pract	s must be sprinklered approved, supervised in accordance with section ription, in REMARKS, of the number of stories, including on which patients are of smoke or fire barriers and . Complete sketch or attach the building as appropriate. On and interview, the facility he limited noncombustible e with LSC Table 19.1.6.1. This ould affect all occupants.	K 0161	What corrective action be accomplished for residents found to hat affected by the deficit practice? No residents, staff or very	on(s) will those ave been ent visitors were	02/29/2024
	p.m. to 4:45 p.m. o structural steel i-be bearing structural s storage room on the entrance for the face	a tour of the facility from 1:55 n 01/17/24, unprotected ams were noted as interior load upports in the wheel chair e ground floor near the main cility on the south side of the n also contained natural gas		affected by the alleged practice. How other residents the potential to be affithe same deficient probe identified and what is a support of the same deficient probe identified and what is a support of the same deficient probe identified and what is a support of the same deficient probe identified and what is a support of the same deficient probe identified and what is a support of the same deficient probabilities.	having fected by ractice will	

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fired furnaces. Based on interview at the time of

stated this portion of the facility was three stories

the observations, the Maintenance Supervisor

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taken?

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corrective action(s) will be

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED				
		155203	B. WI	NG		01/17/	2024
	PROVIDER OR SUPPLIER		•	203 SP	ADDRESS, CITY, STATE, ZIP COD ARKS AVE RSONVILLE, IN 47130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDEDIC DV AV OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
		d unprotected structural steel			All residents, staff and visitors		
		as load bearing structural			could have the potential to be		
		el chair storage room on the			affected by the alleged deficie		
	ground floor.				practice during an emergency		
					related to a fire. On 1/29/24, t		
	_	e reviewed with the Executive			Maintenance Director contacte		
		aintenance Supervisor during			vendor to determine scope an		
	the exit conference.				cost related to encapsulating t		
	3 1-10/b)				exposed I Beams noted in the		
	3.1-19(b)				wheelchair storage room. Ver scheduled for 2/6/24 to provide		
					quote.	-	
					quote.		
					What measure will be put int	0	
					place or what systemic		
					changes will be made to		
					ensure that the deficient		
					practice does not occur?		
					On 1/29/24, Maintenance staft	f	
					was educated on K-161 Buildi	ng	
					Construction LSC section 19.1		
					/whereas exposed load bearin	•	
					structural steel I beams must I		
					encapsulated with an appropri	ate	
					fire rated material. ED and	الماما	
					Maintenance Director inspecte		
					areas of the facility, to ensure identify any other areas with	iO	
					exposed structural steel I bear	ms	
					The wheelchair storage room		
					the only area noted to have		
					exposed structural steel I bear	ms.	
					A vendor has been scheduled		
					2/6/24 to determine scope and	t	
					cost of work to encapsulate th		
					beams with an appropriate fire)	
					rated material. Facility intends	s to	
					update the the facility to meet	this	
					requirement by 2/29/24		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155203		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 01/17/2024			
	PROVIDER OR SUPPLIER		203 SF	ADDRESS, CITY, STATE, ZIP COD PARKS AVE RSONVILLE, IN 47130	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	NFPA 101	A LSC IDENTIFYING INFORMATION	TAG	Additionally, the wheelchair storage room is fully protected the sprinkler system and as a added measure the facility ad an additional fire extinguisher this area on 1/29/24. How the corrective action(s) will be monitored to ensure deficient practice will not recur, ie., what quality assurance program will be pinto place? The Maintenance Director or designee will be responsible fithe completion of the K-1 LSC audit to ensure that all expose load bearing structural steel I beams are encapsulated by appropriate fire rated material. The audits will be completed weekly times 4 weeks, month times 6 months and semiannut thereafter to ensure complian. The results of the audits will be reviewed monthly by the QAP committee overseen by the Administrator. Any areas note be non-compliant with the audit will be corrected. All systemic changes will be completed by 2/29/24.	n ded to to the ded to to the ded to to the ded to the
SS=F Bldg. 01	Egress Doors Egress Doors	d means of egress shall not			
		a latch or a lock that			

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	OF CORRECTION	IDENTIFICATION NUMBER 155203	A. BUILDING B. WING	01	COMPLETED 01/17/2024
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
HILLCRE	ST VILLAGE			RSONVILLE, IN 47130	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE
1710		f a tool or key from the	ing in		BATE
		s using one of the following			
	special locking arr	angements:			
		OR SECURITY THREAT			
	LOCKING				
	•	king arrangements for the			
		eds of the patient are			
	-	king device shall be door and provisions shall			
		ipid removal of occupants			
		of locks; keying of all			
		ed by staff at all times; or			
	-	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				
	ARRANGEMENTS				
	•	king arrangements for the			
	•	e patient are used, all of			
		urity Locking requirements addition, the locks must be			
	-	it fail safely so as to			
		of power to the device; the			
		ed by a supervised			
	automatic sprinkle	r system and the locked			
	space is protected	by a complete smoke			
	detection system (or is constantly monitored			
		ation within the locked			
		he sprinkler and detection			
	-	ged to unlock the doors			
	upon activation.	2 2 5 2 TIA 12 4			
	18.2.2.2.5.2, 19.2. DELAYED-EGRES				
	ARRANGEMENTS				
		elayed-egress locking			
	systems installed i	-			
	7.2.1.6.1 shall be i				
		g low and ordinary hazard			
	contents in buildin	gs protected throughout by			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155203		(X2) MULTIPLE (A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 01/17/2024	
	PROVIDER OR SUPPLIER		203 S	FADDRESS, CITY, STATE, ZIP COD PARKS AVE ERSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	an approved, super detection system of automatic sprinkle 18.2.2.2.4, 19.2.2. ACCESS-CONTR LOCKING ARRAN Access-Controlled installed in accord be permitted. 18.2.2.2.4, 19.2.2. ELEVATOR LOBE LOCKING ARRAN Elevator lobby exi accordance with 7 on door assemblied throughout by an automatic fire dete approved, supervisystem. 18.2.2.2.4, 19.2.2. Based on observation failed to ensure the 4 stairwell exits was residents without a specialized security required means of ewith a latch or lock or key from the egrepermitted by LSC 1 states locks, if provof a key, a tool, or soperation from the earrangements shall with 19.2.2.2.5.2. Taffect all residents, Findings include:	ervised automatic fire or an approved, supervised or system. 2.4 OLLED EGRESS IGEMENTS I Egress Door assemblies ance with 7.2.1.6.2 shall 2.4 BY EXIT ACCESS IGEMENTS It access door locking in 1.2.1.6.3 shall be permitted as in buildings protected approved, supervised action system and an used automatic sprinkler 2.4 on and interview, the facility means of egress through 4 of as readily accessible for clinical diagnosis requiring measures. Doors within a gress shall not be equipped that requires the use of a tool ass side unless otherwise 9.2.2.2.4. LSC Section 7.2.1.5.3 aded, shall not require the use pecial knowledge or effort for agress side. Door-locking are permitted in accordance This deficient practice could	K 0222	K-222 – Egress Doors What corrective action(s) wibe accomplished for those residents found to have bee affected by the deficient practice? No residents, staff or visitors affected by the alleged deficient practice. How other residents having the potential to be affected it the same deficient practice be identified and what corrective action(s) will be taken? All residents, staff and visitors could have the potential to be	02/16/2024 ill en were ent by will
	Supervisor during a	com or the monity month 1.55		Toogramate the potential to be	′ l

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IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155203	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 01/17/2024
ROVIDER OR SUPPLIER		203 SF	ADDRESS, CITY, STATE, ZIP COD PARKS AVE RSONVILLE, IN 47130	
ST VILLAGE SUMMARY (EACH DEFICIEN REGULATORY OF p.m. to 4:45 p.m. or by Room 140, by R Nurse's Station and Nurse's Station wer with an exit sign. E released to open by the stairwell exit do with the following I Building Number". of observations, the agreed the building to everyone that ent have a clinical diag security measures to The Maintenance S doors with the "*Ou These findings were	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LESC IDENTIFYING INFORMATION 101/17/24, the stairwell exit door 100 om 319, by the 2 South by the Moving Forward 10 eeach marked as a facility exit 10 fach stairwell door could be 11 entering a code at a keypad at 12 or but each keypad was posted 13 expyad code notes "*Our 14 Based on interview at the time 15 Maintenance Supervisor 16 number would not be known 17 ers the building that does not 18 nosis requiring specialized 19 actuate the door release. 19 upervisor was able to open the 19 ar Building Number" code. 10 ereviewed with the Executive 10 aintenance Supervisor during		RSONVILLE, IN 47130 PROVIDERS PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROVIDER CORRECTIVE ACTION SHOULD DEFICIENCY) affected by the alleged defi practice during an emerger related to fire or loss of pow On 1/18/24, the Maintenand Director changed all stairwed door codes and added new signs to match the code. The provided is of common know "last digit of next month and digits of 5 years from now ecode. What measure will be put place or what systemic changes will be made to ensure that the deficient practice does not occur? On 1/18/24, Maintenance swas educated on egress do requirements of LSC section 19.2.2.2.5.2 and a K-222 lift safety compliance audit to egress doors whereas all edoors shall have a code himposted and that code hint so a hint that could be known anyone that enters the facil hint must match the code to / exit the facility. On 1/18/2 life safety compliance audit egress doors was performed the Administrator and Maintenance Director using egress door audit tool, all a met compliance standards all provide a hint sign that of known by anyone that enters the facil provide a hint sign that of known by anyone that enters the safety and provide a hint sign that of known by anyone that enters the safety and provide a hint sign that of known by anyone that enters the safety and provide a hint sign that of known by anyone that enters the safety and provide a hint sign that of known by anyone that enters the safety and provide a hint sign that of known by anyone that enters the safety and provide anyone that enters the safety anyone	DATE COMPLETION DATE CIENT C
			facility.	

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	ROVIDER OR SUPPLIEF		203 SP	ADDRESS, CITY, STATE, ZIP COD PARKS AVE RSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LLSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0311 SS=E Bldg. 01	NFPA 101 Vertical Openings Vertical Openings 2012 EXISTING Stairways, elevato ventilation shafts, openings betweer construction havir at least 1 hour. Ar accordance with 8 19.3.1.1 through 1 If all vertical open with construction	- Enclosure or shafts, light and chutes, and other vertical of floors are enclosed with og a fire resistance rating of on atrium may be used in 6.6.	IAU	How the corrective action(s) will be monitored to ensure deficient practice will not recur, ie., what quality assurance program will be pinto place? The Maintenance Director or designee will be responsible fithe completion of the life safet compliance audit of egress do The audits will be completed weekly times 4 weeks, monthit times 6 months and semiannuthereafter to ensure compliance. The results of the audits will be reviewed monthly by the QAP committee overseen by the Administrator. Any areas note be non-compliant with the audit will be corrected. All systemic changes will be completed by 2/16/24	the ut or ty pors. ly pally poe. e I

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Event ID:

CO0821

Facility ID: 000110

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02/08/2024 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 01/17/2024 155203 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 203 SPARKS AVE HILLCREST VILLAGE JEFFERSONVILLE, IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Based on observation and interview, the facility K 0311 K-311 – Vertical Openings 02/29/2024 failed to maintain protection of 1 of 5 interior What corrective action(s) will stairwells. LSC 19.3.1 requires vertical openings be accomplished for those shall be enclosed or protected in accordance with residents found to have been Section 8.6. LSC 8.6.1 requires every floor that affected by the deficient separates stories in a building shall be practice? 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 No residents, staff or visitors were states the separation shall have a minimum 1-hr affected by the alleged deficient fire resistance rating where the exit connects three practice. stories or less. Existing penetrations shall be protected in accordance with 8.3.5. This deficient How other residents having practice could affect over 20 residents, staff and the potential to be affected by visitors in the vicinity of the 1 West Nurse's the same deficient practice will Station. be identified and what corrective action(s) will be Findings include: taken? Based on observations with the Maintenance 20 residents, staff and visitors Supervisor during a tour of the facility from 1:55 could have the potential to be p.m. to 4:45 p.m. on 01/17/24, the stairwell door by affected by the alleged deficient the Mechanical Room by the 1 West Nurse's practice during an emergency Station was equipped with a self closing device related to a fire. On 1/18/24, and a latching mechanism on the stairwell door Maintenance Director inspected but the door failed to latch into the door frame the stairwell door by the when tested to close multiple times. The latching mechanical room by 1 west mechanism on the door was "dogged down". The nurses' station. Adjustments stairwell door was equipped with a 90 minute fire made without success. A vendor resistance rating label. Based on interview at the was contacted, and repairs are time of the observations, the Maintenance scheduled for 2/6/24. Supervisor agreed the aforementioned stairwell door failed to latch into the door frame to enclose What measure will be put into the vertical opening with a minimum 1-hour fire place or what systemic resistance rating. changes will be made to ensure that the deficient These findings were reviewed with the Executive practice does not occur? Director and the Maintenance Supervisor during the exit conference. On 1/18/24. Maintenance staff was educated on K-311 Vertical

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3.1-19(b)

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Openings related to LSC section

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	OF HEALTH AND HU MEDICARE & MEDIC							02/08/2024 ROVED 938-039
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155203	` ′	JILDING	ONSTRUCTION 01	(X3) DATE COMPL 01/17/	ETED	?
NAME OF PROVIDER OR SUPPLIER HILLCREST VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 203 SPARKS AVE JEFFERSONVILLE, IN 47130					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. 19.3.1 and a K-311 life safety compliance audit tool for verti openings. On 1/18/24, a life safety compliance audit on ve openings was performed by t Administrator and Maintenand Director using the K-311 Vert openings audit tool, 1 of 5 are did not meet compliance standards, vendor scheduled 2/6/24 to perform repairs.	ical ertical he ce ical ea's	COMP	X5) LETION ATE

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

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NFPA 101

Hazardous Areas - Enclosure

K 0321

SS=E

Event ID:

CO0821

Facility ID: 000110

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			ETED
		155203	B. WI	NG		01/17/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ARKS AVE		
HILLCRE	ST VILLAGE				RSONVILLE, IN 47130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 01	Hazardous Areas	- Enclosure					
	Hazardous areas	are protected by a fire					
	barrier having 1-h	our fire resistance rating					
		rated doors) or an					
	automatic fire exti	nguishing system in					
	accordance with 8	3.7.1 or 19.3.5.9. When the					
	approved automa	tic fire extinguishing system					
	option is used, the	e areas shall be separated					
	from other spaces	s by smoke resisting					
	partitions and doo	ors in accordance with 8.4.					
	Doors shall be sel	lf-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 Separation	Automatic Sprinkler N/A					
	•	-Fired Heater Rooms					
	b. Laundries (larg	er than 100 square feet)					
		nance, and Paint Shops					
	d. Soiled Linen Ro	ooms (exceeding 64					
	gallons)						
	e. Trash Collectio	n Rooms					
	(exceeding 64 gal	llons)					
	f. Combustible Sto	orage Rooms/Spaces					
	(over 50 square fe	eet)					
	g. Laboratories (if	classified as Severe					
	Hazard - see K32	,					
		on and interview, the facility	K 0.	321	K-321 – Hazardous Areas -		02/16/2024
		f over 21 hazardous areas such			Enclosure		
		rooms were separated from			What corrective action(s) wil	ı	
		oke resistant partitions and			be accomplished for those		
	doors. Doors shall	be self closing or automatic			residents found to have been	n	
	closing in accordan	ce with 7.2.1.8. This deficient			affected by the deficient		
practice could affect over 5 residents, staff and				practice?			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED				
		155203	B. WI	ING		01/17/	2024
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 203 SPARKS AVE JEFFERSONVILLE, IN 47130				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE N. I.V. OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	entrance of the facil building.	nd floor near the main lity on the south side of the			No residents, staff or visitors v affected by the alleged deficie practice.		
	Supervisor during a p.m. to 4:45 p.m. or noted in the ceiling room on the ground for the facility on the The room contained Based on interview observations, the M the aforementioned storage room ceiling hazardous area from resistant partitions. These findings were	aintenance Supervisor agreed openings in the wheel chair g did not separate this n other spaces with smoke e reviewed with the Executive aintenance Supervisor during			How other residents having to 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 of potentially be affected by the alleged deficient practice during event related to fire. This area only used for storage, only authorized staff have access. 1/30/24, the Maintenance Direct assessed all 41 storage areas unsealed wall penetrations, 1 noted, all penetrations sealed using fire caulk. What measure will be put interplace 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 hazardou area's LSC section 19.3.5.9 at 19.3.2.1 a life safety compliant audit tool for "Hazardous Area whereas all wall and ceiling penetrations must be patched Sealed with fire caulk. On 1/30/24, The life safety compliance audit for hazardous	e De	
					areas was performed by the	•	

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AND PLAN OF CORRECTION IDE		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155203	(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/17/2024			
		100200	<u> </u>	ADDRESS, CITY, STATE, ZIP COD	31/11/2024		
	PROVIDER OR SUPPLIER EST VILLAGE	8	203 SPARKS AVE JEFFERSONVILLE, IN 47130				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)		
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
				Administrator and Maintenance Director, all storage rooms au- and met compliance related to wall and ceiling penetrations. How the corrective action(s)	dited		
				will be monitored to ensure t			
				deficient practice will not			
				recur, ie., what quality	4		
				assurance program will be p into place?	ut		
				The Maintenance Director or			
				designee will be responsible for			
				the completion of the life safet	-		
				compliance audits of hazardou areas. The audits will be	ıs		
				completed weekly times 4 weekly	eks,		
				monthly times 6 months and			
				semiannually thereafter to ensign continued compliance. The	sure		
				results of the audits will be			
				reviewed monthly by the QAP	l		
				committee overseen by the	. 44-		
				Administrator. Any areas note be non-compliant with the aud			
				will be corrected.			
				All systemic changes will be completed by 2/16/24			
K 0351	NFPA 101						
SS=E	Sprinkler System	- Installation					
Bldg. 01	Spinkler System -	Installation					
	2012 EXISTING	and becomitted as the second					
	Nursing homes, a by construction ty	nd hospitals where required					
	1 -	pe, are protected approved automatic					
	1	n accordance with NFPA					

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13, Standard for the Installation of Sprinkler

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CO0821

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 01/17/2024 155203 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 203 SPARKS AVE HILLCREST VILLAGE JEFFERSONVILLE, IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 K 0351 K-351 - Sprinkler System -02/16/2024 failed to maintain the ceiling construction for 1 of Installation What corrective action(s) will 3 ceilings in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA be accomplished for those 13, 2010 edition, Section 6.2.7.1 states plates, residents found to have been escutcheons, or other devices used to cover the affected by the deficient annular space around a sprinkler shall be metallic, practice? or shall be listed for use around a sprinkler. This deficient practice could affect over 10 residents, No residents were affected by the staff and visitors. alleged deficient practice. Findings include: How other residents having the potential to be affected by Based on observations with the Maintenance the same deficient practice will Supervisor during a tour of the facility from 1:55 be identified and what p.m. to 4:45 p.m. on 01/17/24, gaps and cracks corrective action(s) will be were noted in escutcheons for ceiling mounted taken? sprinklers in the following areas: a. in Room 120. 10 residents, staff and visitors b. in the Laundry Services Room by the 1 West have the potential to be affected Nurse's Station. by the alleged deficient practice c. in the bathroom in the West Dining Room. during an emergency related to a Based on interview at the time of the fire. On 1/22/24, maintenance observations, the Maintenance Supervisor agreed director adjusted the escutcheons

the escutcheons for the aforementioned sprinkler

in room 120, Landry services

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155203		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/17/2024	
	PROVIDER OR SUPPLIER		203 SF	ADDRESS, CITY, STATE, ZIP COD PARKS AVE ERSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
locations each had gaps and cracks which did not maintain the ceiling construction. These findings were reviewed with the Executive			Room by 1 west nurses' stati- and the bathroom in the west dining room to eliminate gapp		
		aintenance Supervisor during		What measure will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur? On 1/22/24, Maintenance sta was educated on NFPA 13 section 6.2.7.1 to ensure that escutcheons were properly secured to the sprinkler head no gapping should be presen 1/22/24, Maintenance Director Administrator audited all sprin 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 constandards. How the corrective action(si will be monitored to ensure deficient practice will not recur, ie., what quality assurance program will be printo place? The Maintenance Director or designee will be responsible the completion of the Sprinkle Head Audits. The audits will completed weekly times 4 we monthly times 6 months and	ff all and t. On or and okler de the the for er be

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CO0821 Facility ID: 000110

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE A. BUILDING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED		
		155203	B. WING		01/17/2024	
	PROVIDER OR SUPPLIE EST VILLAGE	R	203 \$	ET ADDRESS, CITY, STATE, ZIP COD SPARKS AVE FERSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME DEFICIENCY) semiannually thereafter to er continued compliance. The results of the audits will be reviewed monthly by the QAI committee overseen by the Administrator. Any areas no be non-compliant with the au will be corrected.	DATE Insure Pl ted to	
K 0353 SS=E Bldg. 01	Sprinkler System Automatic sprinkl are inspected, tes accordance with Inspection, Testir Water-based Fire Records of syster inspection and tes secure location a	- Maintenance and Testing - Maintenance and Testing er and standpipe systems sted, and maintained in NFPA 25, Standard for the ag, and Maintaining of Protection Systems. In design, maintenance, sting are maintained in a and readily available. It system last checked		All systemic changes will be completed by 2/16/24		
	coverage for any automatic sprinkle 9.7.5, 9.7.7, 9.7.8 1. Based on observ failed to maintain accordance with N the Inspection, Tes Water-Based Fire I	RKS information on non-required or partial er system.	K 0353	K-353 – Sprinkler System – Maintenance and Testing What corrective action(s) w be accomplished for those residents found to have be affected by the deficient	ill	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETE			ETED	
		155203	B. WING 01/17/2024			2024	
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	3			ARKS AVE		
HILLCRE	EST VILLAGE				RSONVILLE, IN 47130		
	1		1		T	1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG			DATE
	not be subjected to external loads by materials either resting on the pipe or hung from the pipe.				practice?		
	_	cice could affect over 30			No manifesta ataff an visitana v		
	_	visitors in the vicinity of the			No residents, staff or visitors v		
					affected by the alleged deficie	nı	
	Utility Room across from the 1 West Nurse's Station and in the vicinity of Room 325.				practice.		
	Station and in the v	Tellity of Room 323.			How other residents beginn		
	Findings include:				How other residents having		
	rindings include.				potential to be affected by the		
	Rosed on observative	one with the Maintenance			same deficient practice will lidentified and what corrective		
	Based on observations with the Maintenance Supervisor during a tour of the facility from 1:55				action(s) will be taken?	۱	
					action(s) will be taken?		
	p.m. to 4:45 p.m. on 01/17/24, bundled cables were resting on horizontal sprinkler piping in the Utility				30 residents, staff and visitors		
	_	the 1 West Nurse's Station. In			could be affected by the allege		
		cables were affixed with cable			deficient practice during an ev		
		orinkler piping in the attic as			related to fire. On 1/18/24,	ent	
		attic access door near the			maintenance director removed	1 tho	
		Room 325. Based on			data lines that were secured to		
		ne of the observations, the			sprinkler piping in the utility ro		
	Maintenance Super				across from the 1 west nurses		
	_	inkler pipe locations were used			station and the wires noted to		
	to support non-syste				attached to the sprinkler line in		
	to support non syst	em components.			attic by room 325.	Tuic	
	These findings were	e reviewed with the Executive			duo by 100m 020.		
	I	aintenance Supervisor during			What measure will be put int	.	
	the exit conference.	•			place or what systemic	~	
					changes will be made to		
	3.1-19(b)				ensure that the deficient		
					practice does not occur?		
	2. Based on observa	ation and interview, the facility					
		he ceiling construction in 1 of 1			On 1/23/24, Maintenance staf	f	
		py Rooms. NFPA 13, 2010			was educated on the standard		
		.5.4 defines a smooth ceiling as			inspection, testing and		
		g free from significant			maintenance of the fire protect	tion	
		s, or indentations. The ceiling			systems related to NFPA 25		
		ses around the sprinkler and			5.2.2.2 whereas nothing can be	e l	
	cause the sprinkler to operate at a specified				secured to and or obstructing		
		on 8.5.4.1.1 states the distance			sprinkler piping. On 1/23/24	а	
		ler deflector and the ceiling			K-353 sprinkler system audit v		
	above shall be selected based on the type of				performed by the Maintenance		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155203		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/17/2024		
	PROVIDER OR SUPPLIER	2		203 SP	ADDRESS, CITY, STATE, ZIP COD ARKS AVE RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
me	sprinkler and the ty deficient practice co	pe of construction. This bull affect over 5 residents, a the Therapy Room on the		me	Director and the Administrator assess all areas of the facility wires and or items attached to sprinkler lines, all areas met compliance standards.	for	Bitte
	Supervisor during a p.m. to 4:45 p.m. or surrounding three e penetrated a suspen former wall mounte the Therapy Room firestopped to main the room. Based or observations, the Mounte aforementioned Therapy Room did construction for the These findings were	e reviewed with the Executive aintenance Supervisor during			How the corrective action(s) will be monitored to ensure to deficient practice will not recur, ie., what quality assurance program will be pinto place? The Maintenance Director or designee will be responsible for the completion of the life safet compliance audits of the sprin system. The audits will be completed weekly times 4 week monthly times 6 months and semiannually thereafter to ensure continued compliance. The results of the audits will be reviewed monthly by the QAP committee overseen by the Administrator. Any areas note be non-compliant with the audit will be corrected. All systemic changes will be completed by 2/16/24	ut or y kler eks, ure	
K 0920 SS=E Bldg. 01	Extens Electrical Equipment Extension Cords Power strips in a pused for compone	ent - Power Cords and ent - Power Cords and patient care vicinity are only ents of movable ed electrical equipment					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155203	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 01/17/2024
NAME OF PROVIDER OR SUPPLIER HILLCREST VILLAGE			203 SP	ADDRESS, CITY, STATE, ZIP COD ARKS AVE RSONVILLE, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	assembled by quathe conditions of the patient care vinon-PCREE (e.g., except in long-terr do not use PCREI meet UL 1363A of for non-PCREE in (outside of vicinity non-patient care rother UL standard used with general cords are not used wiring of a structu temporarily are recompletion of the installed and mee 10.2.3.6 (NFPA 90, NFPA 70), 590.3 Based on observation failed to ensure 3 of power strips were in fixed wiring. LSC comply with Section electrical wiring an NFPA 70, National NFPA 70, Article 4 specifically permitting shall not be used as a structure. LSC Securic equipment of safety shall be design accordance with NFPA 99, Standard edition, defines pation for a health care facility is defined as vicinity is defined as structures as for a health care facility is defined as vicinity is defined as the condition of the care facility is defined as the	les that have been alified personnel and meet 10.2.3.6. Power strips in cinity may not be used for personal electronics), m care resident rooms that 15. Power strips for PCREE of UL 60601-1. Power strips the patient care rooms (1) meet UL 1363. In pooms, power strips meet 15. All power strips are precautions. Extension 16. The strength of the extension cords used provided immediately upon purpose for which it was to the conditions of 10.2.4. (2), 10.2.4 (NFPA 99), 400-8 (10) (NFPA 70), TIA 12-5 (10) and interview, the facility of 3 extension cords including to tused as a substitute for 19.5.1 requires utilities to 19.5.1 requires utilities to 19.5.1 requires utilities to 19.5.1 requires that, unless ed, flexible cords and cables a substitute for fixed wiring of the extension cords and cables a substitute for fixed wiring of the extension to the extension cords and cables a substitute for fixed wiring of the extension cords and cables a substitute for fixed wiring of the extension cords and provided for life the extension c	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 was affected by the alleged deficie practice. On 1/24/24 the bed nebulizer machine in room 14 was unplugged from the power strip and plugged directly into wall. The bed and refrigerator room 302 were also unplugge from the power strip and plugged directly into the wall. The nebulizer machine in room 31 was also unplugged from the	vere nt and 0 or the in d

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155203		UILDING	onstruction 01	(X3) DATE SU COMPLET 01/17/20	TED
NAME OF I	PROVIDER OR SUPPLIEI	?	•		ADDRESS, CITY, STATE, ZIP COD		
HILLCRE	EST VILLAGE			JEFFE	RSONVILLE, IN 47130		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		6 ft (1.8 m) beyond the normal		TAG	power strip and plugged direct		DATE
		chair, table, treadmill, or other			into the wall.	uy	
	device that support				into the wall.		
		eatment. A patient care vicinity			How other residents having		
		o 7 ft 6 in. (2.3 m) above the			the potential to be affected i	· I	
		ection 10.4.2.3 states household			the same deficient practice	-	
		s not commonly equipped with			be identified and what		
	grounding conducto	ors in their power cords shall			corrective action(s) will be		
		led they are not located within			taken?		
the patient care vicinity. This deficient practice							
could affect over 10 residents, staff and visitors.				10 residents, staff and visitors			
				could have the potential to be			
	Findings include:				affected by the alleged deficie		
					practice in the event of a pow	er	
		ons with the Maintenance			strip failure. On 1/24/24 the		
		tour of the facility from 1:55			Maintenance Director and		
		n 01/17/24, the resident bed, an			Administrator inspected each		
		ine and a charging cable for a device were plugged into a			resident room to ensure NFP		
	-	was affixed to a night stand one			101 requirments for electrical		
		ent bed in Room 140. The			equipment to ensure proper application, type and use of p	ower	
		gerator and two cell phone			strips. Any items found to be		
		re plugged into a power strip			of compliance were adjusted		
		to a night stand one foot from			me meet compliance standard		
		Room 302. An oxygen mask			'		
	machine, a radio an	nd a cell phone charging cable			What measure will be put in	to	
	were plugged into a	a power strip which was affixed			place or what systemic		
	to a night stand one	e foot from the resident bed in			changes will be made to		
		L listing of each of the three			ensure that the deficient		
		363A. Based on interview at			practice does not occur?		
		ervations, the Maintenance					
		a power strip was being used in			On 1/24/24, Maintenance state		
	_	inity for PCREE and			was educated on the appropr		
		a substitute for fixed wiring at three locations in the facility.			use of power strips in patient		
	are arorementioned	unce locations in the facility.			areas that meet "hospital grad approved UL standards and N		
	These findings wer	e reviewed with the Executive			101 requirments for electrical		
		aintenance Supervisor during			equipment. A life safety		
	the exit conference	-			compliance audit was perform	ned	
					to determine proper application		

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155203		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 01/17/2024	
	PROVIDER OR SUPPLIER		203 SF	ADDRESS, CITY, STATE, ZIP COD PARKS AVE ERSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
IAU	3.1-19(b)	LISC IDENTIFT ING INFORMATION	TAU	type and use of power strips. 1/24/24, No new issues were identified, and all affected are identified during survey have corrected.	On eas	
				How the corrective action(s will be monitored to ensure deficient practice will not recur, ie., what quality assurance program will be pinto place? The Maintenance Director or designee will be responsible the completion of the life safe compliance audit on proper application, type and use of pstrips. The audits will be completed weekly times 4 we monthly times 6 months and semiannually thereafter to encompliance. The results of the audits will be reviewed month the QAPI committee oversee the Administrator. Any areas noted to be non-compliant will audits will be corrected. All systemic changes will be completed by 2/16/24	for ety bower eeks, sure ne ne nly by n by	
K 0923 SS=E Bldg. 01	Storag Gas Equipment - 6 Storage Greater than or ec	Cylinder and Container Cylinder and Container qual to 3,000 cubic feet are designed, constructed,				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155203		A. BUILDING B. WING	01	COMPLETED 01/17/2024	
	PROVIDER OR SUPPLIER		203 SP	ADDRESS, CITY, STATE, ZIP COD ARKS AVE RSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	and ventilated in a and 5.1.3.3.3. >300 but <3,000 constructions enclosure or within space of non- or linconstruction, with that can be secured with flamma from combustibles sprinklered) or enconcombustible cominimum 1/2 hr. fill Less than or equal in a single smoke cylinders available patient care areas of less than or equivered to be stored cylinders must be as specified in 11. A precautionary si on each door or garoom, where the saminimum "CAUT STORED WITHIN Storage is planned order of which the supplier. Empty of from full cylinders. cylinders with integent threshold pressure established. Empty avoid confusion. Control of the supplier of the supplier of the supplier of the supplier of the supplier. Empty of the supplier of the supplier of the supplier of the supplier. Empty of the supplier of the supplier. Empty of the supplier of	dubic feet are outdoors in an an enclosed interior mited- combustible door (or gates outdoors) ad. Oxidizing gases are not ables, and are separated by 20 feet (5 feet if closed in a cabinet of construction having a re protection rating. I to 300 cubic feet compartment, individual for immediate use in with an aggregate volume all to 300 cubic feet are not red in an enclosure. handled with precautions 6.2. gn readable from 5 feet is ate of a cylinder storage ign includes the wording as TON: OXIDIZING GAS(ES) NO SMOKING." If so cylinders are used in y are received from the ylinders are segregated When facility employs gral pressure gauge, a e considered empty is ty cylinders are marked to cylinders stored in the open a weather. 3.3, 11.3.4, 11.6.5 (NFPA	K 0923	K - 923 –Gas Equipment –	02/16/2024
		1 indoor oxygen storage ded with a precautionary sign		Cylinder and Container Storage	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 01/17/2024 155203 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 203 SPARKS AVE HILLCREST VILLAGE JEFFERSONVILLE, IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE indicating that smoking in the immediate area is What corrective action(s) will not permitted. NFPA 99 Health Care Facilities be accomplished for those Code, 2012 Edition, Section 11.3.4 states oxygen residents found to have been cylinder and storage locations shall be provided affected by the deficient with a precautionary sign readable from a distance practice? of 5 feet shall be posted on each door or gate of the storage room or enclosure. Section 11.3.4.2 No residents, staff or visitors were states the sign shall include following wording as affected by the alleged deficient a minimum: "CAUTION: OXIDIZING GAS(ES) practice. STORED WITHIN NO SMOKING." This deficient practice could affect over 10 residents, staff and How other residents having visitors in the vicinity of the oxygen storage and the potential to be affected by transfilling room by the Laundry Services room the same deficient practice will across from Room 319. be identified and what corrective action(s) will be Findings include: taken? Based on observations with the Maintenance 10 residents, staff and visitors Supervisor during a tour of the facility from 1:55 could have the potential to be p.m. to 4:45 p.m. on 01/17/24, the oxygen affected by the alleged deficient storage/transfilling room by the Laundry Services practice in the event of a fire room across from Room 319 was not provided emergency. On 1/18/24 a with the necessary signage prohibiting smoking in precautionary sign "No Smoking the immediate area. Eleven liquid oxygen O2 in use" was secured to the containers and 22 'E' type oxygen cylinders were door frame of the only facility O2 observed stored in the room. Based on interview storage area across from room at the time of the observations, the Maintenance 319. Supervisor agreed the oxygen storage/transfilling room across from Room 319 was not provided What measure will be put into with the necessary signage prohibiting smoking. place or what systemic changes will be made to These findings were reviewed with the Executive ensure that the deficient Director and the Maintenance Supervisor during practice does not occur? the exit conference. On 1/18/24, Maintenance staff 3.1-19(b) 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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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPL	COMPLETED		
155203		155203				01/17/	17/2024	
				CTDEET /	ADDRESS CITY STATE ZID COD			
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD ARKS AVE			
HILLCREST VILLAGE					RSONVILLE, IN 47130			
HILLORE	31 VILLAGE			JEFFER	RSONVILLE, IN 47 130			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)		DATE	
					distance of 5 feet shall be pos	ted		
					on the door. On 1/18/24, a life	.		
					safety compliance audit for			
					precautionary signage "No			
					Smoking O2 in use" in place o			
					Oxygen storage room door wa	is		
					performed by the ED and			
					Maintenance director. The sig	jn		
					was observed in place on the			
					Oxygen storage room door. N			
					new issues were identified, an			
					the affected area identified du	ring		
					survey has been			
					corrected.			
					How the corrective action(s)			
					will be monitored to ensure t			
					deficient practice will not	.iie		
					recur, ie., what quality			
					assurance program will be p	ut		
					into place?			
					The Maintenance Director or			
					designee will be responsible for	or		
					the completion of the life safet			
					compliance audit on precautio	-		
					signage. The audits will be	,		
					completed weekly times 4 week	∍ks,		
					monthly times 6 months and	•		
					semiannually thereafter to ens	sure		
					compliance. The results of the			
					audits will be reviewed monthl	y by		
					the QAPI committee overseen	ı by		
					the Administrator. Any areas			
					noted to be non-compliant with	n the		
					audits will be corrected.			
					All systemic changes will be			
					completed by 2/16/24			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
1552		155203	B. WING			01/17/2024	
NAME OF PROVIDER OR SUPPLIER HILLCREST VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 203 SPARKS AVE JEFFERSONVILLE, IN 47130				
(X4) ID PREFIX			ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD I			(X5) COMPLETION	
TAG	· ·		TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
K 0927 SS=E Bldg. 01			K 09		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 waffected by the alleged deficie practice. How other residents having the potential to be affected by the same deficient practice who identified and what corrective action(s) will be taken? 10 residents, staff and visitors could have the potential to be affected by the alleged deficie practice in the event of a fire emergency. On 1/18/24 a	vere nt y	02/16/2024

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155203		A. BUILI B. WING	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/17/2024	
NAME OF PROVIDER OR SUPPLIER HILLCREST VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 203 SPARKS AVE JEFFERSONVILLE, IN 47130					
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY OF Cylinders were observations, the Moxygen transfilling the oxygen storage Room 319 was not indicating that smoon of permitted.	Maintenance Supervisor stated g occurs in the room and agreed transfilling room across from provided with signage oking in the immediate area is the re reviewed with the Executive laintenance Supervisor during	PR	EFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIL DEFICIENCY) precautionary sign "No Smok O2 in use" was secured to the door frame of the only facility storage area across from roor 319. What measure will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur? On 1/18/24, Maintenance stat was educated on NFPA 99 section 11.3.4 whereas oxyge cylinder and storage locations shall be provided with a precautionary sign readable f distance of 5 feet shall be pos on the door. On 1/18/24, a lift safety compliance audit for precautionary signage "No Smoking O2 in use" in place of Oxygen storage room door w performed by the ED and Maintenance director. The si was observed in place on the Oxygen storage room door. In new issues were identified, at the affected area identified du survey has been corrected.	ff en s rom a sted e on as gn	(X5) COMPLETION DATE	
					How the corrective action(s) will be monitored to ensure deficient practice will not recur, ie., what quality assurance program will be pinto place?	the		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155203	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/17/2024			
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 203 SPARKS AVE JEFFERSONVILLE, IN 47130					
(X4) ID PREFIX TAG	(EACH DEFICIE)	MMARY STATEMENT OF DEFICIENCIE DEFICIENCY MUST BE PRECEDED BY FULL TORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DULD BE COMPLETION DATE			
				The Maintenance Director or designee will be responsible for the completion of the life safet compliance audit on precaution signage. The audits will be completed weekly times 4 were monthly times 6 months and semiannually thereafter to ensure compliance. The results of the audits will be reviewed monthal the QAPI committee overseen the Administrator. Any areas noted to be non-compliant with audits will be corrected. All systemic changes will be completed by 2/16/24	y nary eks, ure e y by by			

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