	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING		JILDING	INSTRUCTION	(X3) DATE COMPL 02/20 /	ETED	
	PROVIDER OR SUPPLIER		•	203 SP/	ADDRESS, CITY, STATE, ZIP COD ARKS AVE RSONVILLE, IN 47130		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
E 0000							
Bldg		paredness Survey was diana Department of Health in CFR 483.73.	E 0	000			
	Village was found in Preparedness Requi Medicaid Participate CFR 483.73.	271120 Preparedness survey, Hillcrest in compliance with Emergency rements for Medicare and ing Providers and Suppliers, 42 certified beds. At the time of us was 117.					
K 0000							
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 02/20 Facility Number: 00 Provider Number: 1002 At this Life Safety 0	00110 155203	K 0	000			
I ADOD : mc=	V DIBEOTORIO CO TO	ADED WINDI IED DEDDESS AND			mm p		(VA) DATE
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SI	GNATUR	E	TITLE		(X6) DATE

Mark Bowman Executive Director 03/06/2025

Any defiency statement 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	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155203		JILDING	nstruction <u>01</u>	(X3) DATE S COMPL 02/20 /	ETED
	PROVIDER OR SUPPLIEF	<u> </u>	<u> </u>	203 SP/	ADDRESS, CITY, STATE, ZIP COD ARKS AVE RSONVILLE, IN 47130		
HILLCRE (X4) ID PREFIX TAG	summary (EACH DEFICIEN REGULATORY OF 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 constr The original buildir constructed with mi a two and one-half separating each floo barrier walls, two fi two hour constructi walls with metal stu	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION 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 functed at two different times. In was built in 1966 and fixed construction consisting of finch thick concrete decks for, one hour fire rated smoke for barrier walls constructed of for on each level, brick exterior finds and one-half hour rated forcrete and metal stud interior				TE	(X5) COMPLETION DATE
	trusses and wooden Based on the lowes construction type w construction. The c an open column for south length of the addition including t level 2 East Wing w southeast of the orig foundation was con physical therapy are construction. Becar the addition are the facility was surveyed The facility is fully fire alarm system w levels including the corridors, and has b detectors in all resid	sprinklered. The facility has a rith smoke detection on all corridors, spaces open to the attery operated smoke dent sleeping rooms. The ty of 149 and had a census of					

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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> COMPLET			ETED	
		155203	B. WING 02/20/2025			/2025	
			ST	REET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF F	ROVIDER OR SUPPLIE	R			ARKS AVE		
HILLCRE	ST VILLAGE		JEFFERSONVILLE, IN 47130				
(VA) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIE			<u>. </u>			(V5)
(X4) ID PREFIX				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION
	•	NCY MUST BE PRECEDED BY FULL P. I. S.C. IDENTIFYING INFORMATION			CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE	
K 0211 SS=E Bldg. 01	All areas where reswere sprinkled and services were sprinkled and services were sprin laundry building and Quality Review consultance of Egress 1. Based on observer failed to ensure 1 or egresses were controbstructions. LSC into the required wheeled equipment following condition (a) The wheeled equipment following condition (b) The health care training program as wheeled equipment emergency. (c) The wheeled equipment in used ii. Medical emergency. ii. Medical emergency iii. Patient lift and the This deficient practifacility. Findings include: Based on observatifacility from 11:55 the corridor outside.	repleted on 02/25/25 - General ation and interview, the facility of over 10 corridor means of inuously maintained free of 19.2.3.4 (4) states projections idth shall be permitted for t, provided that all of the ms are met: quipment does not reduce the corridor width to less than 60 occupancy fire safety plan and ddress the relocation of the t during a fire or similar uipment is limited to the e and carts in use mcy equipment not in use transport equipment tice affects 25 residents in the ons and interview with the rvisor (MS) during a tour of the a.m. to 2:45 p.m. on 02/20/25, in the Resident Room # 146 a	K 0211		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 be identified and what corrective action(s) will be taken? 12 residents, staff and visitors could have the potential to be affected by the alleged deficient practice during an emergency event. On 2/20/25, the Maintenance director removed pedestal fan from the corridor room 146 and the lift and wheelchair from the corridor by room 301.	vere nt y vill the by	03/14/2025
l	stationary pedestal	fan was in use. Based on			What measure will be put into	0	

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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 02/20/2025			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 203 SPARKS AVE JEFFERSONVILLE, IN 47130					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREF	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
	interview at the time stated the aforement removed and replace the wall. This finding was actime of discovery at with the MS and AI 2. Based on observation of the continuously maintage or other emerge could affect over 12 needing to exit the firm of the continuously maintage or other emerge could affect over 12 needing to exit the firm of the continuously maintage of the could affect over 12 needing to exit the firm of the could affect over 12 needing to exit the firm of the could be continuously maintage of the could affect over 12 needing to exit the firm of the could be continuously maintage of the could be continuously of the could b	e of observations, the MS tioned fan would need to be ed with one that hung up on knowledged by the MS at the end again at the exit conference of present. Attion and interview, the facility of over 8 means of egress was ained free of all obstructions full instant use in the case of ency. This deficient practice of residents, staff and visitors if facility. Towns and interview with the exit of the a.m. to 2:45 p.m. on 02/20/25, the ent Room # 301, marked a structed with a lift and the directly in front of the exit of the the that staff know better than to of the exit doors. knowledged by the MS at the end again at the exit conference			place or what systemic changes will be made to ensure that the deficient practice does not occur? On 3/3/25, CEN and Maintena Director began in-servicing not staff on the egress door and corridor requirements of LSC section 19.2.3.4 whereas the corridors and means of egress shall be free from obstruction. 3/3/25, a life safety compliance audit on egress doors was performed by the Administrate and Maintenance Director usi the K 211 Means of Egress at tool, all areas met compliance standards as they were free frobstruction. 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 for the completion of the life safe compliance audit on means of egress. The audits will be completed weekly times 4 we monthly times 6 months and semiannually thereafter to ensure compliance. The results of the audits will be reviewed month the QAPI committee overseer the Administrator. If 100% is	ance ursing s. On second udit second the sec		
			1		achieved an action plan will b	е		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155203		A. BUILDING B. WING	<u>01</u>	(X3) DATE SURVEY COMPLETED 02/20/2025		
PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 203 SPARKS AVE JEFFERSONVILLE, IN 47130				
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
NFPA 101 Egress Doors Based on observation failed to ensure the reception main exit residents without a dispecialized security required means of ewith a latch or lock or key from the egrepermitted by LSC 1 arrangements shall the with 19.2.2.2.5.2. The affect over 24, staff the facility. Findings include: Based on observation Maintenance Supervised facility from 11:55 are	on and interview, the facility means of egress through the was readily accessible for clinical diagnosis requiring measures. Doors within a gress shall not be equipped that requires the use of a tool cass side unless otherwise 9.2.2.2.4. Door-locking to permitted in accordance this deficient practice could and visitors if needing to exit the visor (MS) during a tour of the a.m. to 2:45 p.m. on 02/20/25, the		developed. All systemic changes will be completed by 3/14/25 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? 24 residents, staff and visitors could have the potential to be	DATE O3/14/2025 overeent y vill		
could be opened by the code was not po stated that someone recently. This condi surveyor entered the tour. This finding was acl time of discovery ar	entering a four digit code but sted at the exit. The MS had removed the code tion was observed when the facility and again during the knowledged by the MS at the ad again at the exit conference		practice during an emergency related to fire or loss of power. On 2/20/25, the Maintenance Director posted the missing content at the main lobby entrance the receptionist desk. The hin posted is the same throughout facility egress doors. What measure will be put integlace or what systemic	ode e by t t all		
	SUMMARY S (EACH DEFICIENCE REGULATORY OR NFPA 101 Egress Doors Based on observation failed to ensure the reception main exit residents without a conspecialized security required means of exit and a latch or lock or key from the egree permitted by LSC 1st arrangements shall be with 19.2.2.2.5.2. The arrangements shall be with 19.2.2.2.5.2. The facility. Findings include: Based on observation Maintenance Supervation Maintenance Main	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through the reception main exit 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. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 24, staff and visitors if needing to exit the facility. Findings include: Based on observations and interview with the Maintenance Supervisor (MS) during a tour of the facility from 11:55 a.m. to 2:45 p.m. on 02/20/25, the exit door from the main reception area was marked as a facility exit, was magnetically locked and could be opened by entering a four digit code but the code was not posted at the exit. The MS stated that someone had removed the code recently. This condition was observed when the surveyor entered the facility and again during the tour. This finding was acknowledged by the MS at the time of discovery and again at the exit conference with the MS and AD present.	ST VILLAGE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through the reception main exit 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. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 24, staff and visitors if needing to exit the facility. Findings include: Based on observations and interview with the Maintenance Supervisor (MS) during a tour of the facility from 11:55 a.m. to 2:45 p.m. on 02/20/25, the exit door from the main reception area was marked as a facility exit, was magnetically locked and could be opened by entering a four digit code but the code was not posted at the exit. The MS stated that someone had removed the code recently. This condition was observed when the surveyor entered the facility and again during the tour. This finding was acknowledged by the MS at the time of discovery and again at the exit conference	ST VILLAGE SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION REGULATORY OR LSC IDENTIFYING INFORMATION Based on observation and interview, the facility failed to ensure the means of egress through the reception main exit 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. Door-locking arrangements shall be permitted in accordance with 19.2.2.5.2. This deficient practice could affect over 24, staff and visitors if needing to exit the facility. Findings include: Based on observations and interview with the Maintenance Supervisor (MS) during a tour of the facility from 11:55 a.m. to 2:45 p.m. on 02/20/25, the exit door from the main reception area was marked as a facility exit, was magnetically locked and could be opened by entering a four digit code but the code was not posted at the exit. The MS stated that someone had removed the code recently. This condition was observed when the surveyor entered the facility and again during the tour. This finding was acknowledged by the MS at the time of discovery and again at the exit conference with the MS and AD present. 203 SPARKS AVE BPREFIX REGULATORY MUST BE PRECEDED BY FULL PREFIX AM PREFIX AND PREFIX AG VIENCENCENT ALL PROVIDERS HALN OF CORRECTIVE ALON CORRECTIVE ALON CORRECTIVE ACTON SIGNIDATE ALL SYSTEM CORRECTIVE ACTON SIGNIDATE ALL SYSTEM CORRECTIVE STATE ACTON SIGNIDATE ALL SYSTEM CORRECTIVE SUPPLY AND CORRECTIVE STA		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155203	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/20/2025
	ROVIDER OR SUPPLIE	R	203 SP	ADDRESS, CITY, STATE, ZIP COD ARKS AVE RSONVILLE, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				ensure that the deficient practice does not occur?	
				On 3/4/25, Maintenance staff 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 egred doors shall have a code hint posted. On 3/4/24, a life safe compliance audit on egress dowas performed by the Administrator and Maintenance Director using the egress door audit tool, all areas met compliance standards as they provide a hint sign that could known by anyone that enters facility.	ty poors ee r all be
				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 safe compliance audit of egress do a The audits will be completed weekly times 4 weeks, month times 6 months and semiannut thereafter to ensure compliance. The results of the audits will be reviewed monthly by the QAP committee overseen by the Administrator. If 100% is not achieved an action plan will be	the ut or ty pors. ly ually ce. e

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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 01	(X3) DATE SURVEY COMPLETED 02/20/2025			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 203 SPARKS AVE JEFFERSONVILLE, IN 47130				
(X4) ID PREFIX TAG	(EACH DEFICIENCY I	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0223 SS=E Bldg. 01		nd interview, the facility	K 0223	developed. All systemic changes will be completed by 3/14/25 What corrective action(s) will	03/14/2025		
	failed to ensure 2 of over hazardous area enclosure kept in the closed positive release device complying deficient practice could be assed on observations and Maintenance Supervisore facility from 11:55 a.m. Rooms #201 and #202 greater than 50 square from the combustible items, such cardboard boxes. The composition of the doors were equipped when the doors being held op wedged into the doors.	er 30 corridor doors to res are self-closing and ion, unless held open by a ng with 7.2.1.8.2. This affect 15 occupants. and interview with the or (MS) during a tour of the to 2:45 p.m. on 02/20/25, being used for storage, feet, contained a number of the as paper, plastic, and corridor door to these with self-closing devices by fire alarm activiation due ben with chairs and carts	K 0223	be accomplished for those residents found to have been affected by the deficient practice? No residents, staff or visitors of affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice of the same deficient practice outlined and what corrective action(s) will be taken? 15 residents, staff and visitors could have the potential to be affected by the alleged deficient practice during an emergency related to fire. On 2/20/25, the Maintenance Director remove items obstructing door closure from rooms 201 and 202. What measure will be put intended to the practice does not occur?	were ent by will ent e d the		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2)		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED
		155203	B. W	NG		02/20/2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIE	R			ARKS AVE	
HILLCRE	ST VILLAGE				RSONVILLE, IN 47130	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
					On 3/5/25, Maintenance and	
					Nursing staff was educated or	l l
					Doors with Self-closing device)
					requirements of LSC section	:41.
					7.2.1.8.2, whereas, all doors v	
					a self-closing device shall rem closed and not propped open.	
					3/5/24, a life safety complianc	
					audit on doors with self-closin	
					devices was performed by the	_
					Administrator and Maintenand	
					Director. All areas met	
					compliance standards as all	
					storage room doors equipped	with
					a self-closing device were shu	
					How the corrective action(s)	
					will be monitored to ensure t	the
					deficient practice will not	
					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	l l
					compliance audit of egress do	•
					The audits will be completed	
					weekly times 4 weeks, monthl	v
					times 6 months and semiannu	•
					thereafter to ensure compliance	-
					The results of the audits will b	
					reviewed monthly by the QAP	I
					committee overseen by the	
					Administrator. If 100% is not	
					achieved an action plan will be	е
					developed.	
					All systemic changes will be completed by 3/14/25	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		155203	B. WING		02/20/	02/20/2025	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 203 SPARKS AVE JEFFERSONVILLE, IN 47130				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0321 SS=E Bldg. 01	Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 4 of over 15 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 30 residents, staff and visitors. Findings include:		K 0321		What corrective action(s) wil be accomplished for those residents found to have beer affected by the deficient	se	
				Practice? No residents, staff or visitors were affected by the alleged deficient practice.			
	Maintenance Superfacility from 11:55 following was noted A) Room #207 labe than 50 square feet,	ons and interview with the visor (MS) during a tour of the a.m. to 2:45 p.m. on 02/20/25, the d: eled Activities Storage, greater contained a number of such as paper, plastic, and			How other residents having the potential to be affected be the same deficient practice whe identified and what corrective action(s) will be taken?	-	
	cardboard boxes. The corridor door to this room equipped with a self-closing device, failed to self-close and latch due to large amounts of storage in the door way. B) The Business Office, greater than 50 square feet, contained a number of combustible items,				30 residents, staff and visitors could have the potential to be affected by the alleged deficie practice during an emergency. 2/20/25 the obstructed items preventing positive closure an latching in room 207 was remo	nt . On d	
	this office was not edevice. The aforemore common area of recorridor near the managreed the hazardou corridor. These findings were	ardboard boxes. The door to equipped with a self-closing entioned office opens into a seption which is open to the ain reception entrance. The MS as area was open to the main exacknowledged by the MS at y and again at the exit			the door closure and latching in positive. On 3/4/25, the Busin office manager completed the annual file purge process which led to the noted combustible material in the business office. These items have been removant properly stored.	ess ch	
	conference with the MS and AD present. 3.1-19(b)				What measure will be put int place or what systemic changes will be made to ensure that the deficient	o	

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	OF CORRECTION	IDENTIFICATION NUMBER 155203	A. BUILDING B. WING	01	COMPLETED 02/20/2025
	ROVIDER OR SUPPLIER	8	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 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
				practice does not occur? On 3/5/25, Maintenance and Administrative Staff were educ on Hazardous Areas storage requirments related to K-321. 3/5/24, a life safety compliance audit on hazardous storage are was performed by the Administrator and Maintenance Director. All areas met compliance standards as all storage room doors were free obstruction, equipped with a self-closing device that proper latched. How the corrective action(s) will be monitored to ensure the 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 safeth compliance audit on hazardous areas storage. The audits will completed weekly times 4 were monthly times 6 months and semiannually thereafter to ensure the Administrator. If 100% is a achieved an action plan will be developed.	On e rea's ce from rly the ut or ty us I be eks, sure e ly by n by not
				All systemic changes will be	

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	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 203 SPARKS AVE JEFFERSONVILLE, 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)	ATE	(X5) COMPLETION DATE
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Based on observation failed to maintain the Therapy Storage Clair and gases around sprinkler to operate NFPA 13, 2010 edit between the sprinkler and the type deficient practice afforms include: Based on observation Maintenance Superfacility from 11:55 suspended ceiling in was missing ceiling delay the activation interview at the time agreed there were in helper had removed had forgot to replace.	on and interview, the facility the ceiling construction of 1 of 1 coset. The ceiling tiles trap hot if the sprinkler and cause the at a specified temperature. Stion, 8.5.4.11 states the distance for deflector and the ceiling sted based on the type of the period of construction. This feets 5 residents and staff. Some and interview with the evisor (MS) during a tour of the a.m. to 2:45 p.m. on 02/20/25, the in the Therapy Storage Closet tile. This condition could of the sprinklers. Based on the observations, the MS missing ceiling tile stating that a steem to address an issue but the tile. Removed the tile is the tile is the mode of the exit conference in the exit conference.	K 03		What corrective action(s) will be accomplished for those residents found to have been 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 the same deficient practice be identified and what corrective action(s) will be taken? 5 residents, staff and visitors have the potential to be affected by the alleged deficient practice during an emergency. On 2/3 the missing ceiling in the ther closet was replaced. What measure will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?	ill were ent by will could ted ice 21/25 rapy	03/14/2025
					On 3/5/25, Maintenance Staff educated on sprinkler system maintenance and testing rela the missing ceiling tile in the therapy closet. On 3/5/24, a	ı – ted to	

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	OF CORRECTION	IDENTIFICATION NUMBER 155203	A. BUILDING B. WING	01	COMPLETED 02/20/2025
	PROVIDER OR SUPPLIER		203 SF	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 LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				safety compliance audit on sprinkler system maintenance testing was performed by the Administrator and Maintenance Director. All areas met compliance standards as there were no missing ceiling tiles of ceiling breaches in the 44 stor area's audited.	e e r
				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 audit on sprinkler system — maintenance and testing. The audits will be completed weekly times 4 were monthly times 6 months and semiannually thereafter to ensure compliance. The results of the	ut or dy eks,
				audits will be reviewed monthly the QAPI committee overseer the Administrator. If 100% is achieved an action plan will be developed. All systemic changes will be completed by 3/14/25	ly by I by not
K 0921	NFPA 101			Completed by 3/14/23	
SS=F Bldg. 01		ent - Testing and view, observation, and ty failed to conduct the	K 0921	Facility filed ad Life safety Cod Temporary Waiver.	de 05/28/2025

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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 02/20/2025			
NAME OF PROVIDER OR SUPPLIER HILLCREST VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 203 SPARKS AVE JEFFERSONVILLE, IN 47130					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ULD BE COMPLETION PROPRIATE		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	-	ce and maintain complete						
		nspections for Patient Care						
		Equipment (PCREE). NFPA 99 ons 10.3 and 10.5 states the						
	· ·	resistance, leakage current, and						
		for fixed and portable PCREE						
		uired in 10.3. Testing intervals						
		n policies and protocols. All						
		ient care rooms is tested in						
	-	3.5.4 or 10.3.6 before being put						
		er any repair or modification.						
		ing of several electrical						
		trates compliance with NFPA						
	99 as a complete system. Service manuals,							
	instructions, and procedures provided by the							
	manufacturer include information as required by							
		considered in the development						
		ectrical equipment maintenance.						
		nt instructions and maintenance						
	manuals are readily	available, and safety labels						
	and condensed open	rating instructions on the						
	appliance are legibl	le. A record of electrical						
	equipment tests, rep	pairs, and modifications is						
		riod of time to demonstrate						
	•	rdance with the facility's						
		esponsible for the testing,						
		se of electrical appliances						
		training. This deficient						
	practice affects all	residents.						
	The findings includ	le:						
	Based on records re	eview, interview and facility						
		enance Supervisor (MS) and						
		on 02/20/25 between 9:15 a.m.						
		ocumentation was available for						
		ng of the PCREE in use						
		lity, as required by section						
	_	99, Health Care Facilities Code.						
		the building tour revealed that						
	[5						

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
155203			B. WING 02/20/2025				
NAME OF PROVIDER OR SUPPLIER HILLCREST VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 203 SPARKS AVE JEFFERSONVILLE, IN 47130				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0923 SS=E Bldg. 01	The AD stated that nebulizers, oxygen monitors, and other was present and in u Both the MS and Al not aware that the P tested. This finding was ac AD at the time of diconference with each of the storag Based on observation failed to ensure 1 of locations was provious indicating that smooth onto permitted. NFP Code, 2012 Edition cylinder and storage with a precautionary of 5 feet shall be post the storage room or states the sign shall a minimum: "CAU STORED WITHIN practice could affect visitors in the vicinitarins filling room. Findings include: Based on observation Maintenance Superfacility from 11:55 and storage facility	D stated that the facility was CREE was required to be knowledged by the MS and iscovery and again at the exit	K 0	923	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents, staff or visitors vaffected by the alleged deficie practice. How other residents having the potential to be affected by the same deficient practice value 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 deficie practice in the event of a fire emergency. On 2/20/25 a precautionary sign "No Smoking the potential of the same deficiency on 2/20/25 a precautionary sign "No Smoking the same deficiency on 2/20/25 a precautionary sign "No Smoking the same deficiency on 2/20/25 a precautionary sign "No Smoking the same deficiency on 2/20/25 a precautionary sign "No Smoking the same deficiency of	vere nt y vill	03/14/2025

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155203	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 02/20/2025			
	PROVIDER OR SUPPLIEI	₹	203 SI	STREET ADDRESS, CITY, STATE, ZIP COD 203 SPARKS AVE JEFFERSONVILLE, IN 47130				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION eccessary signage prohibiting	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) O2 in use" was secured to th				
	smoking in the imn containers and 'E' to observed stored in	nediate area. Liquid oxygen cype oxygen cylinders were the room. Based on interview oservations, the MS agreed the		door frame of the only facility storage area across from roo 319.	O2			
	oxygen storage/trar provided with the n smoking. The MS s magnetic signage b sign. The MS stated a permanent sign in they were using.	asfilling room was not secessary signage prohibiting searched for the missing that was unable to locate any did that they might need to post astead of the magnetic sign eknowledged by the MS at the and again at the exit conference		What measure will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur? On 3/5/25, Maintenance staff educated on NFPA 99 section 11.3.4 whereas oxygen cylind and storage locations shall be provided with a precautionary readable from a distance of 5 shall be posted on the door. 3/5/25, a life safety compliance audit for precautionary signate "No Smoking O2 in use" in plon Oxygen storage room door performed by the ED and Maintenance director. The signal was observed in place on the Oxygen storage room door, new issues were identified, a the affected area identified dissurvey has been corrected.	was n der e / sign i feet On ce ge ace or was ign e No			
				How the corrective action(s will be monitored to ensure deficient practice will not recur, ie., what quality assurance program will be into place? The Maintenance Director or designee will be responsible	put			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155203		A. BUILDING <u>01</u> B. WING		COMPLETED 02/20/2025			
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 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 0927 SS=E Bldg. 01		Fransfilling Cylinders	K 0027	the completion of the life safet compliance audit on precautio signage. The audits will be completed weekly times 4 weemonthly times 6 months and semiannually thereafter to enscompliance. The results of the audits will be reviewed monthly the QAPI committee overseen the Administrator. If 100% is a achieved an action plan will be developed. All systemic changes will be completed by: 3/14/25	nary eks, sure e y by by not e		
	failed to ensure 1 of was provided with a that smoking in the permitted. NFPA 99 2012 Edition, Section transfilling of liquid with a sign indicating and that smoking in permitted. This definition over 10 residents, stoof the oxygen storage. Findings include: Based on observation Maintenance Supervised in the supervi	n and interview, the facility 1 oxygen transfilling locations precautionary sign indicating immediate area is not 9 Health Care Facilities Code, on 11.5.2.3.1(3) states the oxygen area shall be posted g that transfilling is occurring the immediate area is not icient practice could affect aff and visitors in the vicinity ge and transfilling room. Ins and interview with the visor (MS) during a tour of the a.m. to 2:45 p.m. on 02/20/25, the sfilling room was not	K 0927	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 was identified and what corrective action(s) will be taken? 10 residents, staff and visitors could have the potential to be	vere nt vy vill		

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155203	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>		SURVEY LETED 0/2025			
	PROVIDER OR SUPPLIEF EST VILLAGE		203 SF	STREET ADDRESS, CITY, STATE, ZIP COD 203 SPARKS AVE JEFFERSONVILLE, IN 47130					
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF provided with the n smoking in the imm containers and 'E' t observed stored in t at the time of the of oxygen storage/tran provided with the n smoking. The MS s magnetic signage b sign. The MS stated a permanent sign in they were using. This finding was ac	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LESC IDENTIFYING INFORMATION ecessary signage prohibiting nediate area. Liquid oxygen type oxygen cylinders were the room. Based on interview reservations, the MS agreed the sfilling room was not ecessary signage prohibiting earched for the missing that was unable to locate any I that they might need to post stead of the magnetic sign knowledged by the MS at the and again at the exit conference D present.	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION'S CROSS-REFERENCED TO THE DEFICIENCY) affected by the alleged practice in the event o emergency. On 2/20/2 precautionary sign "No O2 in use" was secured door frame of the only storage area across from 319. What measure will be place or what systems changes will be maded ensure that the deficit practice does not occur. On 3/5/25, Maintenance educated on NFPA 99 11.3.4 whereas oxyge and storage locations	d deficient f a fire 25 a 5 Smoking d to the facility O2 om room e put into ic e to ent cur? ce staff was section n cylinder shall be	(X5) COMPLETION DATE			
				provided with a precauter readable from a distant shall be posted on the 3/5/25, a life safety contaudit for precautionary "No Smoking O2 in us on Oxygen storage rooperformed by the ED at Maintenance director. Was observed in place Oxygen storage roomnew issues were idented the affected area identifications with the affected area identification. How the corrective active will be monitored to expect the corrected will be monitored to expect the correction of	ace of 5 feet door. On mpliance v signage e" in place om door was and The sign e on the door. No iffied, and tiffied during ction(s) ensure the				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155203		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 02/20/2025			ETED			
NAME OF PROVIDER OR SUPPLIER HILLCREST VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 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	
					assurance program will be pinto place? The Maintenance Director or designee will be responsible to the completion of the life safe compliance audit on precautic signage. 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 oversees the Administrator. If 100% is achieved an action plan will be developed. All systemic changes will be completed by: 3/14/25	for onary eks, sure le lly by n by not		

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