| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155203 | A. BUILDING -- B. WING | 12/13/2022 |

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

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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 12/13/22<br><br>Facility Number: 000110<br>Provider Number: 155203<br>AIM Number: 100271120<br><br>At this Emergency Preparedness survey, Hillcrest Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.<br><br>The facility has 149 certified beds. At the time of the survey, the census was 113.<br><br>Quality Review completed on 12/15/22 | E 0000 | /p><br>This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after (1/26/22) | |
| K 0000<br><br>Bldg. 01 | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 12/13/22<br><br>Facility Number: 000110<br>Provider Number: 155203<br>AIM Number: 100271120<br><br>At this Life Safety Code survey, Hillcrest Village was found not in compliance with Requirements | K 0000 | /p><br>This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after (1/26/22) | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Mark Bowman | Executive Director | 12/30/2022 |

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<br><br>Hillcrest Village is a two story building with a finished partial basement. The building was constructed at two different times. The original building was built in 1966 and constructed with mixed construction consisting of a two and one-half inch thick concrete decks separating each floor, one hour fire rated smoke barrier walls, two fire barrier walls constructed of two hour construction on each level, brick exterior walls with metal studs and one-half hour rated drywall, a mix of concrete and metal stud interior walls with one-half hour rated drywall, and metal trusses and wooden rafters in the roof assembly. Based on the lowest construction type, the facility construction type was classified as Type V (111) construction. The original building was built with an open column foundation exposed at the entire south length of the facility. In 1974, a two story addition including the level 1 Transcare Unit and level 2 East Wing was constructed to the southeast of the original building and the column foundation was converted into a poured finished partial basement for physical therapy and is also of Type V (111) construction. Because the original building and the addition are the same type of construction, the facility was surveyed as one building.<br><br>The facility is fully sprinklered. The facility has a fire alarm system with smoke detection on all levels including the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a | | | |

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| | capacity of 149 and had a census of 113 at the time of this survey.<br><br>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except the detached laundry building and storage shed.<br><br>Quality Review completed on 12/15/22 | | | |
| K 0222<br>SS=E<br>Bldg. 01 | NFPA 101<br>Egress Doors<br>Egress Doors<br>Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:<br>CLINICAL NEEDS OR SECURITY THREAT LOCKING<br>Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.<br>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6<br>SPECIAL NEEDS LOCKING ARRANGEMENTS<br>Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised | | | |

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| | automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.<br>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4<br>DELAYED-EGRESS LOCKING ARRANGEMENTS<br>Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4<br>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS<br>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.<br>18.2.2.2.4, 19.2.2.2.4<br>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS<br>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4 | | | |
| | Based on observation and interview, the facility failed to ensure the means of egress through 3 of 11 outside exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a | K 0222 | **K-222 – Egress Doors**<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient** | 12/22/2022 |

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| | required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. LSC Section 7.2.1.5.3 states locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect up to 28 residents, as well as staff and visitors to exit the facility.<br><br>Findings include:<br><br>Based on observations on 12/13/22 between 12:30 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director and Senior Maintenance Supervisor, the front entrance/exit door, 300 north exit door, and the 200 north exit door were posted with the following keypad code notes "*Our Building Number". Based on interview at the time of observations, the Maintenance Director agreed the building number would not be known to everyone that enters the building that does not have a clinical diagnosis requiring specialized security measures to actuate the door release. The Maintenance Director was able to open the doors with the current code.<br><br>This finding was reviewed with the Executive Director, Maintenance Director, and Senior Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | **practice?**<br><br>No residents, staff or visitors were affected by the alleged deficient practice. The code and code hints were changed following survey to reflect a hint that could be known by anyone that enters the facility. The hints and codes were changed to reflect, “35x4-1 = entry code” on the front entrance/exit door, the 300 north exit door, and the 200 north exit doors.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?**<br><br>All residents, staff and visitors could have the potential to be affected by the alleged deficient practice during an emergency that is not related to a fire or loss of power. On 12/29/22, following denial of original code hit, “35x4-1 = entry code” the Maintenance Director audited all egress doors using an egress door audit tool to ensure hint signs were in place and the code to exit provided a hint that could be known by everyone that enters the facility, any codes and or hints identified as not meeting this standard were changed to “Last digit of next month and last 2 digits of next year = entry code” | |

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| | | | **What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur?**<br><br>On 12/14/22, Maintenance staff was educated on egress door requirements of LSC section 19.2.2.2.5.2 and a life safety compliance audit tool for egress doors whereas all egress doors shall have a code hint posted and that code hint shall be a hint that could be known by anyone that enters the facility, the hint must match the code to enter / exit the facility. On 12/30/22, a life safety compliance audit on egress doors was performed by the Administrator and Maintenance Director using the egress door audit tool, all areas met compliance standards as they all provide a hint that could be known by anyone that enters the facility.<br><br>**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?**<br>The Maintenance Director or designee will be responsible for the completion of the life safety compliance audit of egress doors. The audits will be completed | |

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| | | | 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.<br><br>All systemic changes will be completed by 12/30/22 | |
| K 0741<br>SS=E<br>Bldg. 01 | NFPA 101<br>Smoking Regulations<br>Smoking Regulations<br>Smoking regulations shall be adopted and shall include not less than the following provisions:<br>(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.<br>(2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.<br>(3) Smoking by patients classified as not responsible shall be prohibited.<br>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.<br>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas | | | |

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| | where smoking is permitted.<br>(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.<br>18.7.4, 19.7.4<br>Based on observation and interview, the facility failed to ensure cigarette butts were properly disposed of at 1 of 2 area where cigarettes were smoked by residents. This deficient practice could affect at least 5 residents and staff.<br><br>Findings include:<br><br>Based on observations on 12/13/22 between 12:30 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director and Senior Maintenance Supervisor, the resident smoking area in the front courtyard had a large trash can full of paper trash mixed with hundreds of cigarette butts. Based on interview at the time of observation, the Maintenance Director acknowledged the paper trash mixed with cigarette butts in the large trash can.<br><br>This finding was reviewed with the Executive Director, Maintenance Director, and Senior Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | K 0741 | **K-741 – Smoking Regulations**<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>No residents, staff or visitors were affected by the alleged deficient practice. Following survey, the Maintenance assistant immediately emptied the waste receptacle noted to contain cigarette butts.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?**<br><br>All residents, who smoke have the potential to be affected by the alleged deficient practice. On 12/14/22, Maintenance Director audited all smoking areas using a smoking regulation audit tool, no smoking materials were noted to be in the waste receptacle. Maintenance Director also began In servicing all nursing staff to ensure that cigarette waste receptacles are not emptied into | 12/22/2022 |

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| | | | the trash receptacle.<br><br>**What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur?**<br><br>On 12/14/22, Maintenance staff was educated on NFPA 101 smoking regulations and a smoking regulations life safety audit tool. On 12/15/22, a life safety compliance audit on smoking regulations was performed by the Administrator and Maintenance Director, no cigarette materials were noted to be in the trash receptacles. The Maintenance Director or designee will be responsible for the completion of the life safety compliance audit of smoking regulations. The audits will be completed weekly times 4 weeks, monthly times 6 months and semiannually thereafter to ensure continued compliance.<br><br>**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?**<br>The Maintenance Director or designee will be responsible for the completion of the life safety compliance audit of smoking regulations. The audits will be | |

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| | | | 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. . If the threshold of 95% is not achieved an action plan will be developed to ensure compliance.<br><br>All systemic changes will be completed by 12/22/22 | |