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	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Village	203 Sparks Ave Jeffersonville, IN 47130

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation and interview, the facility failed to ensure nursing staff primed the insulin pen's needle prior to dialing the ordered dose during 1 of 4 insulin administrations. (Resident 53) Findings include:During an observation and interview, on 2/24/26 at 11:41 a.m., Resident 53's blood sugar was obtained by Licensed Practical Nurse (LPN) 9 with a reading of 135 milligrams per deciliter (mg/dL). The LPN dialed the Fiasp (fast acting insulin) FlexTouch pen to 25 units without applying a needle. The LPN indicated she had to obtain a second nurse's check on the amount. RN 3 verified the 25 units and checked under the cap. The RN did not say anything and nodded to the LPN it was correct. The needle was then added to the insulin pen by LPN 9. The LPN failed to prime the needle after applying it to the insulin pen. The LPN was stopped from injecting the insulin to the resident. At 11:46 a.m., the LPN 9 indicated she had not primed the needle after she placed it on the insulin pen. The LPN dialed the insulin pen back to zero, then up to 3 units, after priming the needle by expressing the 3 units, the LPN dialed the pen to 25 units and administered the insulin to the resident. The record for Resident 52 was reviewed on 2/25/26 at 9:30 a.m. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus (inability to produce or properly use insulin) with hyperglycemia (high blood sugar). The care plan, dated 4/9/12 and revised 12/23/25, indicated the resident was at risk for adverse effects of hyperglycemia or hypoglycemia (low blood sugar) related to the use of glucose lowering medication and/or diagnosis of diabetes mellitus. The interventions, dated 4/9/12, included, but were not limited to, administer medications as ordered. The physician's order, dated 5/30/25, indicated staff were to administer 25 unit of Fiasp FlexTouch insulin subcutaneously, three times daily, per sliding scale (a diabetes management method where the dose of rapid acting insulin is adjusted based on a person's current blood glucose level). During an interview on 2/25/26 at 10:46 a.m., the DON indicated the only policy she could locate for priming of the insulin needle was the Administration of Medications, dated 11/15/24, included, but was not limited to, . Subcutaneous (SC) Injections. 9. Draw up medication dose. The online corporate policy for Priming Insulin Needles included, but was not limited to, . Key aspects of insulin pen priming policies in this setting include: Mandatory Before Every Injection: Insulin pens must be primed before every injection to remove air bubbles and ensure the pen is working correctly. The dose knob should be turned to 2 units. 410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Village	203 Sparks Ave Jeffersonville, IN 47130

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review, observation, and interview, the facility failed to ensure fall prevention was maintained for residents with muscle weakness during 1 of 5 residents reviewed for accident hazards. (Resident 53) Findings include: The nurse's note by RN 3, dated 12/1/25 at 10:45 a.m., indicated the resident was receiving a bed bath with the assistance of two staff members, Resident 53 was turned to the right side/stomach with the resident's feet crossed, when his feet slipped off the side of the bed and pulled the resident to the floor. The resident received a bruise to the back of the right arm, a long skin tear down his left shin, skin abrasions to the bilateral knees, and scratch like marks to the resident's abdomen. The interdisciplinary team (IDT) note, dated 12/3/25 at 9:36 a.m., indicated a review of the fall on 12/1/25 at 10:45 a.m., indicated during the incident, two staff were giving a bed bath to the resident, when he was turned onto his right side, his legs were crossed and slid off the side of the bed. Upon full body assessment, a bruise was observed to the back of the resident's right arm, bilateral abrasions to his knees, scratch marks to the abdomen and a skin tear down the left shin. The Nurse Practitioner (NP) was informed with new orders to monitor and x-ray the left hip with negative results. The record for Resident 53 was reviewed on 2/25/26 at 9:23 a.m. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy (nerve damage that manifests as tingling, numbness, pain, and muscle weakness), bilateral hearing loss, chronic pain, and repeated falls. The care plan, dated 1/7/25, indicated the resident was at risk for falls due to, but not limited to, repeated falls, bilateral hearing loss, chronic pain, unsteady gait, requires assistance with transfer via mechanical lift, lacks understanding of cognitive and physical limitations, and decreased mobility and weakness. The nurse's note, dated 10/11/25 at 2:05 p.m., indicated the resident voiced an inability to move well, with maximum assistance of two staff for proper positioning in a motorized chair. The resident denied any pain, but indicated, My body just won't move. During an interview, on 2/26/26 at 9:40 a.m., RN 3 indicated the resident had a fall from his bed in early December 2025. Two CNAs (CNA 4 and CNA 5) were giving a bed bath to the resident. One CNA turned to obtain bath supplies and the other was by the bed. The resident was turned onto his side and fell from the bed. The CNA at the bedside should have been there to catch the resident. He could not move well on his own. The new intervention was for a bariatric mattress. During an observation of the resident's care, on 2/26/26 at 9:54 a.m., RN 3 placed the resident's left leg over the right leg onto the mattress. She then pulled the resident toward her and rolled him onto his right side. The resident was unable to assist staff with his mobility/roll. During an interview, on 2/26/26 at 11:20 a.m., the Director of Nursing (DON) indicated Resident 53's care was being provided, the resident already had his legs crossed when the staff turned the resident over, there was a momentum (quantity of motion) and the resident rolled out of bed. The Fall Management Policy, last revised June 2025, included, but was not limited to, Policy: It is the policy of the [corporation name] to ensure residents residing within the community have adequate assistance to prevent injury related to falls. 410 IAC (Indiana Administrative Code) 16.2-3.1-45(a)(1)410 IAC (Indiana Administrative Code) 16.2-3.1-45(a)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure glucometers were cleaned per guidelines for infection control when obtaining blood sugar readings for 2 of 5 residents observed. (Residents 26 and 103) Findings include:1. During an observation, on 2/24/26 8:23 a.m., Qualified Medication Aide (QMA) 6 obtained Resident 59's Accu (blood sugar) check. The QMA left the resident's room, laid the glucometer on the medication cart, and did not clean the glucometer. During an observation, on 2/24/26 at 8:45 a.m., QMA 6 was about to obtain Resident 26's blood sugar. She was stopped due to not having cleaned the glucometer. She obtained a 1 inch by 2-inch alcohol wipe and rubbed the glucometer for 20 seconds. The Staff Development Coordinator 7 reminded the QMA that she had the instructions on her medication cart and laid them on top of the narcotic folder. QMA 6 obtained the resident blood sugar at a reading of 107 milligrams per deciliter (mg/dL). During an interview, on 2/24/26 at 8:55 a.m., QMA 6 indicated she should have cleaned the glucometer after every room. She should have rubbed the glucometer for 1 minute and left dry for 30 seconds. QMA 6 then began reading the instructions, she had used an alcohol wipe to clean the glucometer and should have used the bleach wipe instead. After cleaning the glucometer with the bleach wipe, she should have wrapped it for 3 minutes. 2. During an observation, on 2/24/25 at 11:58 a.m., Licensed Practical Nurse (LPN) 8 obtained the resident's blood sugar and administered insulin to Resident 5. During an interview and observation, on 2/24/26 at 12:03 p.m., LPN 8 indicated she had cleaned the glucometer with an alcohol wipe for a minute to a minute and a half after obtaining the blood sugar for Resident 5. The time observed was 30 seconds of rubbing the glucometer with an alcohol wipe. During an observation, on 2/24/26 at 12:12 p.m., LPN 8 obtained the blood sugar of Resident 103. During an interview, on 2/24/26 at 12:20 p.m., LPN 8 indicated she used an alcohol wipe to clean the glucometer by rubbing it for 1 to 2 minutes. Nurses were not allowed to have Clorox wipes in the medication carts anymore. She asked, Aren't the alcohol wipes just as good? The LPN then indicated she felt the alcohol was just as good. She then cleaned the glucometer for 30 seconds with the Clorox wipe and laid it on the cart to dry. During an interview on 2/24/26 at 12:25 p.m., the Director of Nursing (DON) indicated she felt that the nursing staff could use an alcohol wipe or a bleach wipe to clean the glucometers. They should rub or wrap the glucometer in the wipe for 1 minute and then let it dry for 3 minutes. The glucometer should be cleaned after each resident use. It would be ideal for the medication carts to have two glucometers, so that the glucometer could be cleaned and set to dry while the other glucometer was being used. The Bleach Germicidal Wipes Environmental Protection Agency (EPA) number was EPA 67619-12 (industrial-strength, unscented wipes) cleans and disinfects with efficacy: kills 58 microorganisms in three minutes or less. The Blood Glucose Meter Cleaning/Disinfecting and Testing Skills Competency, last revised May 2021, included, but was not limited to, . Obtain germicidal wipe approved for the glucometer approved for use on glucometer. DO NOT use alcohol preps to clean glucometer, as they are not effective in killing bloodborne pathogens. For .glucometers the cleaning and disinfecting wipe is .Bleach Germicidal Wipes. Wipe entire surface of the blood glucose meter with wipes for 3 minutes. When using .Bleach Germicidal Wipes in the individual packet, it is best to squeeze out excess solution into a trash container or plastic cup to be disposed of. Place cleaned meter on paper towel, in plastic cup, or on clean barrier. Allow meter to completely dry. 410 IAC (Indiana Administrative Code) 16.2-3.1-18(b)(2)