STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155743	A. BUILDING 00 B. WING	10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENHILL MANOR	501 N LINCOLN AVE FOWLER, IN 47944

(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
F 0000 Bldg. 00	This visit was for Investigation of Complaint IN00418396. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00418396 - Federal/State deficiencies related to the allegations are cited at F880 and F9999. Survey date: 10/3/23 Facility number: 000288 Provider number: 155743 AIM number: 100287380 Census Bed Type: SNF/NF: 26 Total: 26 Census Payor Type: Medicare: 1 Medicaid: 21 Other: 4 Total: 26 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 10/6/23.	F 0000	Preparation and or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and or executed solely as required.	
F 0880 SS=F Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of			

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

Kiri Burks 12/05/2023

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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	communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.			

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	(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to properly prevent and or contain COVID-19, related to staff not required to wear masks, testing of residents not completed, screening and signage not available for visitors and staff during a facility outbreak, and not informing there was an outbreak of COVID-19. This had the potential to affect 26 of the 26 residents who resided in the facility. Finding includes: Upon entry of the facility on 10/3/23 at 9 a.m., there were no signs posted at the front visitor	F 0880	**What Corrective Action(s) Will Be Accomplished for Those Residents Found to Have Been Affected by The Deficient Practice:** No residents will be affected by this alleged deficient practice. The facility does not currently have any staff or residents COVID-19 positive. Infection control guidelines will be put in place and implemented. The facility will follow CDC guidelines for masks, and testing of residents during a COVID-19 outbreak. The facility will screen visitors, have mask	11/02/2023

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	entry door that indicated the facility was in an outbreak of COVID-19, no screening forms, and no masks available for visitors to wear. Some of the employees were observed to be wearing surgical masks. Employee 4 indicated it was the person's choice if a mask was worn. During an interview on 10/3/23 at 9:05 a.m., the Administrator indicated there were no COVID-19 positive residents in the facility, though there were residents with respiratory infections. During an interview on 10/3/23 at 12:15 p.m., the Administrator indicated Employee 3 had come to work on 9/19/23 and tested positive for COVID-19. She continued to work while the facility attempted to find someone to come in and cover the shift. During an interview on 10/3/23 at 1:02 p.m., the Administrator indicated Employee 3 had a headache and was not feeling well. She had contacted the Director of Nursing (DON) around 3 a.m. when she tested and was instructed to wear a N95 mask until a relief person arrived at the facility. During an interview on 10/23/23 at 1:20 p.m., Employee 3 indicated on 9/19/23 or 9/20/23, she had a headache and was achy. She had tested herself for COVID-19 when she first arrived at the facility, and after 15 minutes, the card was difficult to read and looked like it had a faint positive line but she was not sure. She continued to work and thought maybe she should test again. She retested herself between 12 a.m. and 1 a.m. and went further into the nasal cavity. This test was positive. She then immediately placed a N95 mask on, gloves and started wiping everything down with the disinfectant wipes and tried to stay away		readily available, and post signage if the facility is in outbreak of COVID-19. Symptomatic employees will test prior to the start of their shift and will not be allowed to work if positive and will be encouraged to stay home if they are ill. Any employee that tests positive will not work and if they test positive while at the facility, they will be required to leave the facility immediately; if they are the only licensed personnel present, they will be required to remain in a non-resident care area until another licensed staff member can arrive to relieve them. The facility will notify all appropriate parties if the facility is in a COVID-19 outbreak. **How Other Residents Having the Potential to Be Affected by The Same Deficient Practice Will Be Identified and What Corrective Action(s) Will Be Taken:All residents residing in the facility have the potential to be affected. No other residents will be affected by this alleged deficient practice.** Infection control guidelines will be put in place and implemented. The facility will follow CDC guidelines for masks, and testing of residents during a COVID-19 outbreak. The facility will screen visitors, have mask readily available, and post signage if the facility is in outbreak of COVID-19. Symptomatic	

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	from everyone. She text the DON, Administrator and the ADON a picture of the test. She received a call back from the ADON around 3:34 a.m. and was told to wear a N95 and try to stay at least six feet from everyone. She indicated the N95 mask was worn, she double gloved and changed them after each task, and continually wiped down every item with the disinfectant wipes. The Time Card Report indicated Employee 3 had exited the facility at 8 a.m. on 9/20/23. The residents were all tested on 9/21/23 and were negative. No other tests were performed. The Long Term Care Respiratory Surveillance Line List was reviewed on 10/3/23 at 2:21 p.m., with the Administrator. There were two employees listed, Employee 1 and Employee 2, who had symptoms and tested positive to COVID-19. The Administrator indicated Employee 3 had also tested positive and had not been placed on the list yet. Review of the schedules and time sheets indicated Employee 1 had not been working in the facility when she first experienced symptoms of COVID-19. She tested positive the third day of the symptoms and had not worked in the facility. Employee 2 experienced symptoms on 8/30/23 of a headache and had tested negative. She tested on 9/3/23 and had tested positive for COVID-19 and was sent home from the facility. The residents of the facility were tested for COVID-19 one time on 9/3/23 and were negative. The Administrator indicated no further testing had been completed after the 9/3/23 tests of the		employees will test prior to the start of their shift and will not be allowed to work if positive and will be encouraged to stay home if they are ill. Any employee that tests positive will not work and if they test positive while at the facility, they will be required to leave the facility immediately; if they are the only licensed personnel present, they will be required to remain in a non-resident care area until another licensed staff member can arrive to relieve them. The facility will notify all appropriate parties if the facility is in a COVID-19 outbreak. **What Measures Will Be Put into Place and What Systemic Changes Will Be Made to Ensure That the Deficient Practice Does Not Recur:**b=""> **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:**ADON/Designee will complete IP rounds during scheduled workdays daily for 3 months, then weekly times 3 months, then monthly ongoing to ensure continued compliance. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly.	

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	residents until 9/21/23 and no further testing of the residents was completed after 9/21/23. If residents had symptoms of COVID-19, they were tested. The Administrator indicated she had not realized one employee or resident constituted an outbreak status for COVID-19. She indicated the facility had not initiated precautions of masks, nor signage at the door to inform visitors of the outbreak status. A COVID-19 exposure policy, dated 2/13/20 and received from the Administrator as current, indicated the facility would follow the recommendations of the CDC (Centers for disease Control and Prevention) for infection prevention and control. A facility source control policy for masks, dated 9/23/22 and received as current from the Administrator, indicated staff were not required to wear masks of any kind unless they were listed as a high transmission community or were in an active COVID-19 outbreak. If the facility was under an outbreak status, all staff were expected to wear N95 masks during resident care and interaction until 14 days of no new cases occurred. Vaccination status would not affect the requirement related to mask use in any facility. The facility was to provide visual signage at the entrance and strategic areas recommending masks be worn. Visitors would not be required to wear masks inside the building unless the facility was under a COVID-19 outbreak status. If in outbreak status, visitors will only be required to wear surgical masks, and N95's if visiting a positive status resident. Masks were to be available for staff, residents, and visitors. This Federal tag relates to Complaint IN00418396.			

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	3.1-18(b) 3.1-18(b)(1)			
F 9999 Bldg. 00	16.2-3.1-13 Administration and management (g) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any: (A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents. This State rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure the Indiana Department of Health (IDOH) had been notified of an epidemic outbreak of respiratory infections for over 10% of the residents who reside in the facility. During a review of the facility's Infection Control Surveillance form with the ADON on 10/3/23 at 4:12 p.m., there were seven of the 26 residents (26.9%) with a respiratory illness. There were two residents diagnosed on 9/18/23, one resident	F 9999	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** No residents will be affected by this alleged deficient practice. The facility will submit an initial report to IDOH for all required incidents per the IDOH reporting guidelines. **How Other Residents Having the Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:**All residents residing in the facility have the potential to be affected, no other residents will be affected by this alleged deficient practice. The facility will submit an initial report to IDOH for all required incidents per the IDOH reporting guidelines. **What Measures Will Be Put into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:**All staff, including the Administrator will be in-serviced over the IDOH reporting guidelines. Administrator/Designee will be responsible for filing timely reports	11/02/2023

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	diagnosed on 9/20/23, and four residents diagnosed on 9/24/23. The ADON indicated the respiratory illness outbreak had not been reported to the IDOH. This state finding relates to Complaint IN00418396.		and follow up reports to IDOH when indicated.**How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:**Administrator/Designee will monitor Reportable/Unusual Occurrence Log weekly times 3 months, then monthly times 3 months. Any negative findings will be corrected immediately and forwarded to the Regional Director of Operations. A report on progress will be forwarded to the QA Committee monthly for a minimum of 6 months and the plan adjusted accordingly.	