STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE	X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 00		COMPLETED		
		155743	B. W	B. WING			12/02/2021	
				CTREET	ADDRESS SITY STATE ZID CODE			
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE			
ODEENII	III I MANOD				INCOLN AVE			
GREENF	IILL MANOR			FOWLE	ER, IN 47944			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY 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	
F 0000								
Bldg. 00								
			F 00	000	This plan of correction is to se	rve		
	This visit was for a	Recertification and State			as Sugar Creek Nursing and			
	Licensure Survey.				Rehab Center's credible allega			
					of compliance. Submission of	this		
	-	ember 29, 30, December 1 and			plan of correction does not			
	2, 2021.				constitute an admission by Su			
					Creek Nursing and Rehab Cer			
	Facility number: 0				or its management company t			
Provider number: 155743 AIM number: 100287380				the allegations contained in the	е			
				survey report are a true and				
					accurate portrayal of the provi			
	Census Bed Type:				of nursing care and other serv	ices		
	SNF/NF: 34				in the facility, nor does this			
	Total: 34				submission constitute an	_		
	C D T				agreement or admission of the	;		
	Census Payor Type Medicare: 1	2:			survey allegations.			
	Medicaid: 24							
	Other: 9							
	Total: 34							
	10tai. 54							
	These deficiencies	reflect State Findings cited in						
	accordance with 41	_						
	accordance with 41	10 II C 10.2-3.1.						
	Quality review con	nnleted on 12/7/21						
		inpleted on 12/7/21.						
F 0641	483.20(g)							
SS=D	Accuracy of Asse	essments						
Bldg. 00	§483.20(g) Accur	acy of Assessments.						
	The assessment	must accurately reflect the						
	resident's status.	-						
	Based on record re	view and interview, the	F 06	541	What Corrective Action(s) W	ill	12/25/2021	
	facility failed to en	sure the Minimum Data Set			Be Accomplished For Those			
	(MDS) assessment	s were accurately completed			Residents Found To Have Be	en		
	related to medication	ons for 1 of 14 MDS			Affected By The Deficient	ļ		
	assessments review	ved. (Resident 35)			Practice:			
					Resident 35 will have no nega	tive		
	i		1		İ		Ī	

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155743	B. WING 12/02/2021			2021	
				I CTREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1			
00551					INCOLN AVE		
GREENH	IILL MANOR			FOWLE	ER, IN 47944		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWINED'S DEAN 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
	Finding includes:				affect related to this alleged		
	C				deficient practice. MDS		
	Resident 35's record	d was reviewed on 12/1/21 at			assessment for Resident 35 h	as	
		ses included, but were not			been corrected. Resident 35 w		
		lisorder, hypertension, and			have an accurately completed		
	major depressive di				MDS per schedule.		
	inajor aspressive ai				How Other Residents Having	.	
	The Quarterly Mini	mum Data Set (MDS)			The Potential To Be Affected		
		0/30/21, indicated the			The Same Deficient Practice	-,	
	resident had not rec				Will Be Identified And What		
		the assessment look back			Corrective Action(s) Will Be		
	period.	the assessment rook suck			Taken:		
	period.				All residents residing in the fac	cility	
	The Medication Ad	ministration Record (MAR),			have the potential to be affected	-	
		cated the resident had			by this alleged deficient praction		
	received Lasix (furd				No other residents were affect		
	· ·	igrams (mg) twice a day.			by this alleged deficient praction	I	
	medication) 40 mm	igrains (ing) twice a day.			All residents will have an	Je.	
	Intorviory with the	Administrator on 12/1/21 at					
					accurately completed MDS pe schedule.	4	
	-	ed she was not aware of the			What Measures Will Be Put I		
	error.					ilo	
	2.1.21(.)(()				Place and What Systemic		
	3.1-31(c)(6)				Changes Will Be Made To		
	3.1-31(d)(3)				Ensure That The Deficient		
					Practice Does Not Recur:		
					All residents will have an		
					accurately completed MDS pe	4	
					schedule. MDS coordinator		
					in-serviced over "Resident	.	
					Assessment Instrument" policy	y	
					and procedure.	,	
					How The Corrective Action(s		
					Will Be Monitored To Ensure		
					The Deficient Practice Will N	ot	
					Recur:		
					MDS coordinator/Designee wi	I	
					monitor all completed resident		
					MDS's for accurate completion		
					weekly times 2 months, then e	-	
					2 weeks times 2 months, then		
1	i		1		1	I	

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Event ID:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/30/2021 FORM APPROVED OMB NO. 0938-0391

	of correction identification NU 155743	UMBER: A.	BUILDING WING	NSTRUCTION 00	COMPLETED 12/02/2021		
GREENH	PROVIDER OR SUPPLIER HILL MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (EACH DEFICIENCY MUST BE PRECEI REGULATORY OR LSC IDENTIFYING IT	DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				monthly times 2 months. Any negative findings will be corre immediately and forwarded to Administrator. A report of progress will be forwarded to QAPI committee monthly for minimum of 6 months and pla adjusted accordingly.	the		
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Comprehensive Person-Comprehensive Person-Comprehensive Person-Comprehensive Person-Comprehensive Person-Comprehensive Plans §483.21(a)(1) The facility must devimplement a baseline care plan for resident that includes the instruction to provide effective and person-cencare of the resident that meet profestandards of quality care. The base plan must- (i) Be developed within 48 hours of resident's admission. (ii) Include the minimum healthcare information necessary to properly comprehension orders. (C) Dietary orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (E) Social services. (F) PASARR recommendation, if applications of the comprehensive care plan in place of baseline care plan if the comprehension- (i) Is developed within 48 hours of resident's admission. (ii) Meets the requirements set forthere.	relop and each ns needed ntered essional eline care a care for a co- n orders. pplicable. elop a of the nsive care the					

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155743	B. WING		12/02/2021	
	PROVIDER OR SUPPLIEI HILL MANOR	2	501 N I	ADDRESS, CITY, STATE, ZIP CODE LINCOLN AVE ER, IN 47944		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	l	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident.					
	(ii) A summary of and dietary instru	the resident's medications ctions.				
	 (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the 					
	details of the com	prehensive care plan, as				
	necessary. Based on record review, and interview, the facility failed to develop an initial plan of care within 48 hours of admission for 1 of 14 residents whose care plans were reviewed. (Resident 186)		F 0655	What Corrective Action(s) W Be Accomplished For Those Residents Found To Have Be Affected By The Deficient Practice: Resident 186 will have no neg	een	
	Finding includes:			affect related to this alleged deficient practice. A baseline of		
	The record for Resident 186 was reviewed on 12/1/21 at 9:52 a.m. Diagnoses included, but were not limited to, psychotic disorder with delusions, bipolar disorder, and general anxiety disorder. The resident was admitted to the facility on 11/19/21.			plan has been developed for Resident 186 How Other Residents Having The Potential To Be Affected The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be	1	
	There was a lack of	documentation any baseline		Taken:		
	care plan had been	completed upon admission.		All residents residing in the fact have the potential to be affect.	-	
	Interview with the	Administrator on 12/1/21 at		by this alleged deficient praction		
		ed the baseline care plan had		No other residents were affect		
	not been completed.			by this alleged deficient practic A baseline care plan will be		
	3.1-35(c)(2)(C)			developed within 48hours of a resident admitting to the facilit		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/30/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155743	B. WING 12/02/2021			/2021	
			<u> </u>	CTD FFT A	ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE				
ODEEN	III I MANIOD		501 N LINCOLN AVE				
GREENE	IILL MANOR			FOWLE	ER, IN 47944		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL]	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA:	rc	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	· C	DATE
					What Measures Will Be Put In	nto	
					Place and What Systemic		
					Changes Will Be Made To		
					Ensure That The Deficient		
					Practice Does Not Recur:		
					A baseline care plan will be		
					developed within 48hours of a	new	
					resident admitting to the facilit		
					All licensed nursing staff will b	е	
					in-serviced over the "Care Pla	n	
					Development and Review" pol	icy	
					and procedure.	-	
					How The Corrective Action(s)	
					Will Be Monitored To Ensure		
					The Deficient Practice Will No	ot	
					Recur:		
					ADON/Designee will audit nev	1	
					admissions chart on the next		
					scheduled workday to ensure	the	
					baseline care plan has been		
					developed timely. Any negativ	е	
					findings will be corrected		
					immediately and forwarded to	the	
					Administrator. A report of		
					progress will be forwarded to t	he	
					QAPI committee monthly for		
					minimum of 6 months and plar	า	
					adjusted accordingly.		
F 0695	483.25(i)						
SS=D		neostomy Care and					
Bldg. 00	Suctioning						
	- ,, ,	ratory care, including					
	_	e and tracheal suctioning.					
		ensure that a resident who					
	needs respiratory						
		e and tracheal suctioning,					
		care, consistent with					
	•	dards of practice, the					
	comprehensive p	erson-centered care plan,					

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 00 155743 B. WING 12/02/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 501 N LINCOLN AVE **GREENHILL MANOR** FOWLER, IN 47944 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) the residents' goals and preferences, and 483.65 of this subpart. F 0695 What Corrective Action(s) Will Based on observation, record review, and 12/25/2021 Be Accomplished For Those interview, the facility failed to provide proper Residents Found To Have Been respiratory care and or services for residents receiving oxygen for 2 of 2 residents reviewed Affected By The Deficient Practice: for oxygen. (Residents 34 and 14) Resident 14 and 34 will have no Findings include: negative affect due to this alleged deficient practice. Resident 14's 1. On 11/29/21 at 10:18 a.m., Resident 14 was O2 tubing, and humidification observed lying in her bed. She had a nasal cannula bottle was dated, and order on for oxygen delivery. There was no date on the obtained to change O2 tubing and oxygen tubing or humidification bottle to humidification bottle and to date indicate when it was last changed. them weekly. MD order for Resident 34 was verified that O2 The resident's record was reviewed on 11/30/21 was to be on 2I PM. O2 level on at 1:07 p.m. The resident was admitted on concentrator was adjusted to 8/1/19. Diagnoses included, but were not limited 2LPM. to, chronic obstructive pulmonary disease and **How Other Residents Having** she was receiving hospice services. The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What A Physician's order, dated 2/7/20, indicated the resident was to receive oxygen by nasal cannula Corrective Action(s) Will Be at 2 liters per minute, with humidity, Taken: continuously. All residents have the potential to be affected by this alleged There was not an order to indicate when the deficient practice. No other tubing and humidity bottle should be changed. residents were affected by this The November 2021 Treatment Administration alleged deficient practice. O2 for Record (TAR) did not have any information as to resident's will be administered at when the tubing and humidity bottle were last the flow directed by the physician order. O2 tubing, humidification changed. bottle, and/or other disposable O2 Interview with the Administrator, on 11/30/21 at equipment will be changed weekly 1:36 p.m., indicated oxygen tubing and humidity and will be dated for the day it bottles should be changed weekly, and was changed. documented on the TAR. She indicated there was What Measures Will Be Put Into

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no documentation when the resident's tubing was

last changed, but would correct it at that time.2.

Event ID:

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Facility ID: 000288

Place and What Systemic

Changes Will Be Made To

If continuation sheet Page 6 of 19

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155743	B. WING 12/02/			2021	
				CTREET	ADDRESS OF A TE ZID CODE		
NAME OF F	ROVIDER OR SUPPLIER	t		1	ADDRESS, CITY, STATE, ZIP CODE		
					INCOLN AVE		
GREENF	IILL MANOR			FOWLE	ER, IN 47944		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DECLUDED ON AN 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' DEFICIENCY)	T.C.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	IE.	DATE
	On 11/29/21 at 2:23	3 p.m., Resident 34 was			Ensure That The Deficient		
		ed. The resident had oxygen			Practice Does Not Recur:		
		cannula. The oxygen			O2 for resident's will be		
		and set at 2.5 liters.			administered at the flow direct	ed	
					by the physician order. O2 tub	ing,	
	On 11/30/21 at 11:38 a.m., Resident 34 was				humidification bottle, and/or ot	-	
		ed. The resident had oxygen			disposable O2 equipment will	be	
		cannula. The oxygen			changed weekly and will be da		
	concentrator was on and set at 2.5 liters.				for the day it was changed. All		
					licensed nursing staff will be		
	Record review for Resident 34 was completed				in-serviced over the "Oxygen		
	on 11/30/21 at 12:02 p.m. Diagnoses included,				Therapy" policy and procedure) .	
	but were not limited to, traumatic brain				How The Corrective Action(s)	
	dysfunction and respiratory failure.				Will Be Monitored To Ensure		
					The Deficient Practice Will No	ot	
	The Annual Minim	um Data Set (MDS)			Recur:		
	assessment, dated 1	0/18/21, indicated the			ADON/Designee will monitor ()2	
	resident was cogniti	ively intact. The resident			tubing, humidification bottle,		
	required an extensiv	ve 2+ person assist for bed			and/or other disposable O2		
	mobility and transfe	ers.			equipment and O2 flow weekly	/	
	The resident receive	ed oxygen therapy.			times 2 months, then 2 times a month times 2 months, then	a	
	A Physician's Order	r, dated 10/11/21, indicated			monthly tims 2 months. Any		
	-	ygen) at 2 liters every shift.			negative findings will be correct	cted	
	01461 101 02 (0A	Jan, at 2 mets every smit.			immediately and forwarded to		
	Interview with LPN	I 1 on 11/30/21 at 11:41 a.m.,			Administrator. A report of		
		ht the resident was supposed			progress will be forwarded to t	he	
	_	ne would have to double			QAPI committee monthly for		
		The oxygen concentrator was			minimum of 6 months and plan	ı	
	not set to the correc				adjusted accordingly.		
					, , , , , , , , , , , , , , , , , , , ,		
	A policy titled, "Ox	tygen Therapy", and received					
		Assistant Director of					
		, indicated, "Procedure: 12.					
	_	ate at the prescribed liter flow					
		for administration device"					
	"Supply Change Out 1. All disposable supplies						
	used by a resident N						
	•						
	3.1-47(a)(6)						

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PRINTED: 12/30/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155743		A. BUILDING B. WING	00	COMPLETED 12/02/2021			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IS CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION		
F 0727 SS=C Bldg. 00	§483.35(b) Regist §483.35(b)(1) Exc paragraph (e) or (facility must use the nurse for at least § 7 days a week. §483.35(b)(2) Exc paragraph (e) or (facility must design serve as the direct basis. §483.35(b)(3) The serve as a charge facility has an ave 60 or fewer reside Based on record reverside facility failed to ensconsecutive RN (Reference and failed fail	ept when waived under f) of this section, the ne services of a registered B consecutive hours a day, ept when waived under f) of this section, the nate a registered nurse to tor of nursing on a full time e director of nursing may nurse only when the rage daily occupancy of nts. riew and interview, the nure there were 8 hours of egistered Nurse) coverage for riewed, this had the potential	F 0727	What Corrective Action(s) Be Accomplished For Thore Residents Found To Have Affected By The Deficient Practice: No residents were affected alleged deficient practice. To facility will have 8 consecuti hours of RN coverage 7 day week. How Other Residents Havi The Potential To Be Affect The Same Deficient Practic Will Be Identified And What Corrective Action(s) Will Be Taken: All residents residing in the have the potential to be affet by this alleged deficient practic by this alleged deficient practic	by this he ve /s a ng ed By ce at de facility ected ctice. ected		

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Event ID:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/30/2021 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155743		A. BUILDING B. WING	00	COMPLETED 12/02/2021
	ROVIDER OR SUPPLIER		501 N L	ADDRESS, CITY, STATE, ZIP CODE LINCOLN AVE ER, IN 47944	l
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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
				The facility will have 8 consect hours of RN coverage 7 days week. What Measures Will Be Put I Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur: The facility will have 8 consect hours of RN coverage 7 days week. Assistant Administrator Administrative nursing staff in-serviced over regulation regarding required RN covera How The Corrective Action(s Will Be Monitored To Ensure The Deficient Practice Will N Recur: Administrator/Designee will monitor staffing on scheduled workdays daily ongoing to ensuppropriate daily RN coverage Any negative findings will be corrected immediately and forwarded to the Regional Direction of Operations. A report of progress will be forwarded to QAPI committee monthly for minimum of 6 months and plat adjusted accordingly.	nto cutive a a and ge. b) cutive acand the cutive acand ge. b) cutive acand a
F 0744 SS=D Bldg. 00	diagnosed with de appropriate treatm or maintain his or physical, mental, a well-being.	esident who displays or is mentia, receives the nent and services to attain her highest practicable	F 0744	What Corrective Action(s) W	fill 12/25/2021

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Event ID:

KTS711

Facility ID: 000288

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SI	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLE	TED
		155743	B. W	B. WING 12/02/2021			021
				_		, v _, _	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
					INCOLN AVE		
GREEN	HILL MANOR			FOWLE	ER, IN 47944		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		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 APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	review, the facility failed to provide appropriate services for a resident with dementia for 1 of 1				Be Accomplished For Those		
					Residents Found To Have B	een	
	residents reviewed	for dementia care. (Resident			Affected By The Deficient		
	26)				Practice:		
					Resident 26 will have no nega	ative	
	Finding includes: The following observations of Resident 26 were made: On 11/30/21 at 9:40 a.m., the resident was				affect related to this alleged		
					deficient practice. Resident de	oes	
					receive 1 on 1 with activities a	and	
					documentation of such will oc	cur.	
					How Other Residents Having	g	
	observed seated in the dining room at a table				The Potential To Be Affected	d By	
	alone, his eyes were closed. At 2:25 p.m., he				The Same Deficient Practice	,	
	was laying in his b	ed with his eyes closed. There			Will Be Identified And What		
	was no television of	or radio in his room.			Corrective Action(s) Will Be		
					Taken:		
	On 12/1/21 at 11:2	9 a.m., 1:30 p.m., and 3:03			All residents residing in the fa	cility	
	p.m., he was laying	g in his bed with his eyes			have the potential to be affect	ted	
	closed.				by this alleged deficient practi	ice.	
					All residents that receive 1 on	1	
	On 12/2/21 at 10:1	5 a.m., the resident was in bed			with activities will have such		
	with his eyes close	d. At 12:12 p.m., the resident			activity documented after eac	h	
	was seated in the d	ining room at a table alone			occurrence.		
	with his eyes close	d. At 1:20 p.m., the resident			What Measures Will Be Put I	nto	
	was propelling him	nself backward down the			Place and What Systemic		
	hallway.				Changes Will Be Made To		
					Ensure That The Deficient		
	The resident's reco	rd was reviewed on 11/30/21			Practice Does Not Recur:		
	at 2:27 p.m. The re	esident was admitted to the			All residents that receive 1 on	1	
	facility on 9/8/20.	Diagnoses included, but were			with activities will have such		
	not limited to, Alzl	neimer's dementia. The Annual			activity documented after eac	h	
	Minimum Data Set	t assessment, dated 11/12/21,			occurrence. Activity Director a	and	
		ent had significant cognitive			activity assistants will be		
		eded extensive assistance for			in-serviced over the "One to O	One	
	bed mobility and tr				Programming" policy and		
					procedure.		
	The Dementia care	plan indicated the resident			How The Corrective Action(s	s)	
		o music, keeping up with the			Will Be Monitored To Ensure	-	
	news, and doing things with groups of people.				The Deficient Practice Will N		
	_	eated he will participate in 1 on			Recur:		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155743	B. WING 12/02/2021			/2021	
				CTDEET A	ADDRESS CITY STATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
ODEENII	III I MANOR				INCOLN AVE		
GREENF	IILL MANOR			FOWLE	ER, IN 47944		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1 activities with sta	aff three times a week.			Activity Director/Designee will		
					monitor all 1 on 1 visits for		
		mentation the resident had			appropriate documentation 2		
	received 1 on 1 vis	sits from staff since 7/21/21.			times a week times 2 months,	then	
	The resident's Nov	ember activity log indicated he			weekly times 2 months, then 2	<u>)</u>	
	participated in one	group activity a week; he had			times a month times 2 months		
	attended two other	activities but did not			Any negative findings will be		
	participate.				corrected immediately and		
			1		forwarded to the Administrator	. A	
	Interview with the	Dietary Manager, who was			report of progress will be		
temporarily assisting with the activity program, on 12/2/21 at 10:35 a.m., indicated they had not had an Activity Director since July. A new				forwarded to the QAPI commit			
				monthly for minimum of 6 mor			
				and plan adjusted accordingly			
		and been hired the previous					
	-	ant would come in three times					
	-	1 on 1's with residents, but did					
	not document any	of those activities.					
	3.1-37						
F 0759	483.45(f)(1)						
SS=D	Free of Medication	on Error Rts 5 Prcnt or More					
Bldg. 00	§483.45(f) Medica	ation Errors.					
	The facility must	ensure that its-					
	§483.45(f)(1) Med	dication error rates are not					
	5 percent or grea	ter;					
	Based on observati	ion, record review, and	F 075	59	What Corrective Action(s) W	ill	12/25/2021
	interview, the facil	ity failed to ensure a			Be Accomplished For Those		
	medication error ra	ate of less than 5% for 2 of 6			Residents Found To Have Be	en	
	residents observed	during medication pass. Two			Affected By The Deficient		
		ed during 26 opportunities for			Practice:		
	-	cation administration. This			Resident 5 and 21 will have no)	
		eation error rate of 7.69%.			negative affect related to this		
	(Residents 5 and 21)				alleged deficient practice. Nas		
	E. 1				spray for Resident 5 was prime		
Findings include:			1		MD was notified of Resident 2	-	
				only receiving 5mg of Glyburid			
		33 a.m., the Director of	1		How Other Residents Having		
	Nursing (DON) wa	as observed giving medications			The Potential To Be Affected	ву	

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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 00 155743 B. WING 12/02/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 501 N LINCOLN AVE **GREENHILL MANOR** FOWLER, IN 47944 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) to Resident 5. She had a bottle of fluticasone (a The Same Deficient Practice nasal spray), she inserted the tip of the bottle Will Be Identified And What into one nostril and sprayed once, then into the Corrective Action(s) Will Be other nostril and sprayed once. The resident indicated she wasn't sure the medication had been All residents residing in the facility dispensed. The DON then primed the bottle a have the potential to be affected. couple times, and then repeated the medication No other residents were affected administration. by this alleged deficient practice. What Measures Will Be Put Into Interview with the DON after the observation, **Place and What Systemic** indicated she should have primed the bottle of Changes Will Be Made To fluticasone before administering. **Ensure That The Deficient Practice Does Not Recur:** 2. On 12/1/21 at 10:02 a.m., QMA 1 was Residents will receive all observed preparing medications to Resident 21. medications as ordered by their She prepared one tablet of of glyburide, 5 physician at the scheduled time. milligrams (mg), in addition to the other All licensed and qualified nursing medications. staff will be i-serviced over the following policy and procedures A Physician's order, dated 8/27/21, indicated "Medication Errors, Administration Procedures for All Medications, glyburide 5 mg, 2 tablets every morning. and Nasal Administration". On 12/1/21 at 11:23 a.m., the DON confirmed **How The Corrective Action(s)** the order and indicated the resident should have Will Be Monitored To Ensure The Deficient Practice Will Not received 2 tablets of glyburide. Recur: ADON/Designee will observe 5 3.1-48(c)(1)medication administrations at varying times weekly times 2 month, then every 2 weeks times 2 months, then monthly times 2 months. 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 minimum of 6 months and plan adjusted accordingly.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/30/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155743		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	COMPLETED 12/02/2021
	PROVIDER OR SUPPLIER HILL MANOR	501 N L	ADDRESS, CITY, STATE, ZIP CODE INCOLN AVE R, IN 47944	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
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 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;			

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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 00 COMPLETED				ETED
		155743	B. W	ING		12/02/	/2021
NAME OF F	AN OLUMBER OR GURBLUE			STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	· ·	501 N LINCOLN AVE				
	IILL MANOR			FOWLE	ER, IN 47944		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG				TAG	DEFICIENCY		DATE
	, ,	v isolation should be used luding but not limited to:					
		duration of the isolation,					
		he infectious agent or					
	organism involved	-					
	_	t that the isolation should be					
		e possible for the resident					
	under the circums						
	(v) The circumsta	nces 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						
	, ,	nvolved in direct resident					
	contact.	Troived in direct resident					
	- ' ' ' '	ystem for recording					
		d under the facility's IPCP					
		e actions taken by the					
	facility.						
	§483.80(e) Linens						
		andle, store, process, and					
	•	o as to prevent the spread					
	of infection.						
	§483.80(f) Annua	I review.					
		nduct an annual review of					
		ate their program, as					
	necessary.				l <u>.</u>		
		on, record review, and	F 08	380	What Corrective Action(s) W		12/25/2021
	control guidelines v	ity failed to ensure infection			Be Accomplished For Those Residents Found To Have Be		
	_	ding those to prevent and/or			Affected By The Deficient	, C11	
	-	, related to lack of hand			Practice:		
		dication pass and not cleaning			Residents 5, 19, and 21 were	not	
		r 3 of 6 residents observed			affected by this alleged deficie		
	-	pass, (Residents 5, 21 and 19),			practice. Hand hygiene will be		
							l

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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 00		COMPLETED		
		155743	B. W	B. WING 12/02/2		′2021 l	
				CENTER	A DDDDGG GYTY GT ATE TID GODE		-
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
					INCOLN AVE		
GREEN	HILL MANOR			FOWLE	ER, IN 47944		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF C		RRECTION (X5)	
PREFIX	(EACH DEFICIENCY 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		
		eyewear worn by staff and			performed when appropriate or		
		ntrol surveillance which had			indicated, shared equipment will		
	_	ect all 34 residents in the		be disinfected between use,			
	facility.				proper eye wear will be worn		
					when required, and infection		
	Findings include:				control logs have been undate		
					How Other Residents Having	-	
		33 a.m., the Director of			The Potential To Be Affected By		
		s observed during medication			The Same Deficient Practice		
	1 ~	. The DON prepared the			Will Be Identified And What		
	medications without performing hand hygiene.				Corrective Action(s) Will Be		
	She then administered the medications to the				Taken:		
	resident, and performed hand hygiene after.				All residents residing in the fa	-	
	T				have the potential to be affect		
		DON after the medication			No other residents were affect		
	observation, she indicated she had forgot to				by this alleged deficient practi		
	perform hand hygiene before preparing the medications.				Hand hygiene will be performe		
	medications.				when appropriate or indicated shared equipment will be	,	
	2. On 12/1 21 at 0.55 a m. OMA 1 was				disinfected between use, prop	or	
	2. On 12/1 21 at 9:55 a.m., QMA 1 was observed giving medications to a resident in the				eye wear will be worn when	CI	
		emoved a pulse oximeter from			required, and infection control		
	1 -	red it on the resident's finger.			logs have been undated.		
		imeter back into her pocket			What Measures Will Be Put I	nto	
	without cleaning it either before or after use.		Place and		Place and What Systemic		
					Changes Will Be Made To		
	At 10:02 a.m., the 0	QMA was observed giving			Ensure That The Deficient		
		ident 21. She removed the			Practice Does Not Recur:		
	oximeter from her	pocket and placed it on the			Hand hygiene will be performe	ed	
	resident's finger. Sh	ne then placed it back in her			when appropriate or indicated	,	
	pocket. The oxime	ter had not been cleaned			shared equipment will be		
	between the two res	sidents.			disinfected between use, prop	er	
					eye wear will be worn when		
	Interview with the	QMA after Resident 21's			required, and infection control		
	medication administration, indicated she should		logs have been undated. All staff				
	have cleaned the oximeter between resident				will be in-serviced over "how to		
					don/doff PPE with return		
		01 p.m., QMA 2 was			demonstration, proper hand		
		medications for Resident 19.			hygiene with return		
	The QMA did not perform hand hygiene prior to				demonstration, proper eye		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155743		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/02/2021				
NAME OF PROVIDER OR SUPPLIER GREENHILL MANOR			501 N I	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE COMPLETION DATE			
	observation, she inchand hygiene before The current policy, was received from at 12:14 p.m., indicand water prior to b "Use alcohol gel or resident unless usin 11/29/21 at 10:46 a medication cart. The protective eye wear was fully vaccinate protection because residents on TBP (to precautions). She for only nurse working shift. On 12/1/21 at 9:46 medications. The Ohad a gap at the top indicated she was to appropriate to wear. The local county Control of Transmission was appropriate to wear. The Indiana Depart Infection Control of Facilities updated 1 substantial or high of eye protection shour residents within 6 for direct care regardless.	QMA after the medication licated she had not performed be preparing the medications. "Medication Administration", the Administrator on 12/1/21 lated, "Wash hands with soap beginning med pass" and, or foam before between each group soap and water"4. On lam., LPN 1 was observed at a line nurse did not have on. The nurse indicated she drand did not need to wear eye the facility did not have any transmission based further indicated she was the with all the residents that a.m., QMA 1 was preparing QMA had on a face shield that of the shield. The QMA old the face shield was		protection and when requiver wear it, and infection control practices during medication administration. The facility Infection Control Assessmobeen completed (Attachmer Root Cause Analysis (RCA) (Attachment B) for the facility been conducted. All staff vin-serviced over CDC guid regarding proper eye protect and when it is required to (Attachment C). How The Corrective Action Will Be Monitored To Ensity The Deficient Practice Will Recur: ADON/Designee will comprounds during scheduled workdays daily for a minimal weeks, then weekly time weeks. Any negative finding be corrected immediately forwarded to the Administration of progress will be forwarded to the QAPI commonthly for minimum of 6 and plan adjusted according to the control of the plan adjusted according to the progress will be forwarded to the QAPI commonthly for minimum of 6 and plan adjusted according to the plan adjusted according to the progress will be forwarded to the QAPI commonthly for minimum of 6 and plan adjusted according to the progress will be forwarded to the QAPI commonthly for minimum of 6 and plan adjusted according to the progress will be forwarded to the QAPI commonthly for minimum of 6 and plan adjusted according to the progress will be forwarded to the QAPI commonthly for minimum of 6 and plan adjusted according to the progress will be forwarded to the QAPI commonthly for minimum of 6 and plan adjusted according to the progress will be forwarded to the QAPI commonthly for minimum of 6 and plan adjusted according to the progress will be forwarded to the QAPI commonthly for minimum of 6 and plan adjusted according to the progress will be forwarded to the QAPI commonthly for minimum of 6 and plan adjusted according to the progress will be forwarded to the QAPI commonthly for minimum of 6 and plan adjusted according to the progress will be forwarded to the progress wil	rol in LTC ent has ent A). A A) dity has vill be delines ection be worn con(s) sure dill Not collete IP num of des 12 des will and crator. A mmittee months			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/30/2021 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155743	A. BUILDING B. WING	A. BUILDING 00		COMPLETED 12/02/2021	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE			
GREENH	ILL MANOR			INCOLN AVE ER, IN 47944			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 9999	gaps at top, bottom, 5. The monthly Info Logs Binder was rev a.m. The binder lac infection control sur the months of Octob Interview with the A 11:30 a.m., indicated documentation the r surveillance was cor October and Novem who had been comp there and did not sho the line listing and t before she left. An Infection Contro "Surveillance" and r Assistant Director o indicated, "Data C MONTHLY: The IF information from th tabulate incidence o data shall be summa and by pathogen, us patterns/trends. 5. M shall compare incide	or sides of eyes" Dection Control Surveillance viewed on 12/2/21 at 11:00 ked any documentation that reveillance was completed for over and November 2021. Administrator on 12/2/21 at d d she could not find any monthly infection control impleted for the months of ober 2021. The staff member leting them no longer worked ow anyone how to complete the monthly surveillance Al Manual policy titled, received as current from the f Nursing on 12/2/21, collection And Recording 4. December 2021 of infection. The infection of infection in the framework of the surveillance logs and for type(s) of infection. The infection of infection in the infection of current infections to If an increase is noted,					
Bldg. 00		44.				ı	
	3.1-13 Administration	on and Management	F 9999	What Corrective Action(s) Wi	ill	12/25/2021	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (2)			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		COMPLETED	
		155743	B. WING		12/02/2021	
				CTREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER						
					LINCOLN AVE	
GREENF	HILL MANOR			FOWLE	ER, IN 47944	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	DROVIDED'S DI AN OF CODDECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG				TAG	DEFICIENCY)	DATE
					Be Accomplished For Those	
	(g) The administrate	or is responsible for the			Residents Found To Have Be	een
	overall managemen	at of the facility. The			Affected By The Deficient	
	_	he administrator shall			Practice:	
	_	limited to, the following:			Resident 20 will not have any	
		ivision within twenty-four			adverse effects related to this	
		ning aware of an unusual			alleged deficient practice. Initia	al
	occurrence that dire	_			reports for all unusual	
		or health of a resident.			occurrences will be reported in	n
		occurrence may be made by			required timeframe.	
	telephone, followed				How Other Residents Having	
		en report only that is faxed or			The Potential To Be Affected	
	sent by electronic mail to the division within the				The Same Deficient Practice	
	twenty-four (24) hour time				Will Be Identified And What	
		currences include, but are not			Corrective Action(s) Will Be	
	limited to:	,			Taken:	
	(A) epidemic outbreaks;				All residents have the potentia	al to
	(B) poisonings;				be affected, no other residents	
	(C) fires; or				were affected by this alleged	
	(D) major accidents.				deficient practice. Initial report	s
					for all unusual occurrences wi	
	This rule was not met as evidenced by:				reported in required timeframe	e.
	,				What Measures Will Be Put I	
	Based on record review and interview, the				Place and What Systemic	
	facility failed to ensure an unusual occurrence				Changes Will Be Made To	
	was reported to the Indiana Department of Health				Ensure That The Deficient	
	(IDOH), related to a	a fall that required staples for			Practice Does Not Recur:	
1 of 3 residents reviewed for accidents.				All staff, including Administrate	or	
	(Resident 20)				will be in-serviced over	
					Abuse/Neglect and ISDH	
	Finding includes:				Reportable Unusual Occurren	ce
					policy and procedures.	
	The record for Resi	dent 20 was reviewed on			Administrator/Designee will be	•
	11/30/21 at 12:11 p.m. Diagnoses included, but			responsible for filling timely reports		oorts
	were not limited to, osteoarthritis, hypertension,		and follow up reports if indicated.			
	and anxiety disorder. The resident was admitted				How The Corrective Action(s	
	to the facility on 9/30/21.				Will Be Monitored To Ensure	•
					The Deficient Practice Will N	ot
	The Admission Mir	nimum Data Set (MDS)			Recur:	
assessment, dated 10/7/21, indicated the resident				Administrator/Designee will		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		COMPLETED		
155743		B. WING		12/02/2021			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE				
GREENHILL MANOR			FOWL	ER, IN 47944			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION)	TAG		DATE		
		lls since admission including		monitor Reportable/Unusual			
	one with major inju	ıry.		Occurrence Log weekly times	3		
				months, then monthly times 3			
	_	n, dated 10/1/21, indicated the		months. Any negative findings	will		
	resident fell in the doorway of her bathroom and			be corrected immediately and			
		foot board of her bed. She		forwarded to the Regional Dire	ector		
		a 4-5 inch laceration to the		of Operations. A report of			
		ith moderate bleeding and was		progress will be forwarded to t	he		
	1	cy room for evaluation and		QA Committee monthly for			
	treatment.			minimum of 6 months and plar	ו		
		110/1/01		adjusted accordingly.			
	_	ated 10/1/21 at 9:31 p.m.,					
		ent was found in the doorway					
		d was noted to have a large					
		ck of her head. The resident					
	was sent to the eme	ergency room for evaluation.					
	A Progress Note, d	ated 10/2/21 at 5:30 a.m.,					
	indicated the reside	ent had returned from the					
	emergency room w	ith 11 staples to the back of					
	her head.						
	Intomvior	Administrator on 12/1/21 at					
	_	ed the fall had not been She was not aware the fall had					
	_	lent receiving staples.					
	resulted in the resid	ient receiving stapies.					
	A facility policy, ti	tled Indiana State Department					
		of Long Term Care Incident					
		eceived as current from the					
		cated "C. Types of incidents					
		ate rules only5. Major					
	accidents-unexpected or unintentional events						
	_	cture or other outcomes that					
require medical treatment beyond							
	or ER/physician ev						
		i		ı			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KTS711

Facility ID: 000288

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