STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155743	A. BUILDING -- B. WING	12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENHILL MANOR	501 N LINCOLN AVE FOWLER, 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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/15/21 Facility Number: 000288 Provider Number: 155743 AIM Number: 100287380 At this Emergency Preparedness survey, Greenhill Manor was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 64 certified beds. At the time of the survey, the census was 34. Quality Review completed on 12/20/21	E 0000	This plan of correction is to serve as Greenhill Manor Nursing and Rehabilitation Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission of Greenhill Manor Nursing and Rehabilitation Center or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in the facility, nor does this submission constitute an agreement or admission of the survey allegations.	
E 0004 SS=C Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable			

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

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	Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to develop and maintain an	E 0004	**What Corrective Action(s) Will Be Accomplished For Those**	01/14/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan entitled "Emergency Preparedness Program" on 12/15/21 between 12:30 p.m. to 1:20 p.m. with the facility Acting Administrator present, documentation for an Emergency Preparedness program reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan available had not been reviewed within the past 12 months with the last documented date of review being listed as 08/12/2019. Based on interview at the time of record review, the Acting Administrator said the facility has not had its emergency preparedness program reviewed by the facility within the most recent twelve-month period because the previous Administrator is no longer at this facility and the Administrator is currently in the role of Acting Administrator as of the time of this survey so had not yet had time to review or update the Emergency Preparedness Plan. During the exit conference with the Acting Administrator and the Maintenance Man at 3:25 p.m., no additional information or evidence could be provided contrary to this deficient finding.		**Residents Found To Have Been Affected By The Deficient Practice:** No residents were affected by this alleged deficient practice. The Emergency Preparedness Plan will be reviewed by the facility. **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 have the potential to be affected, no other residents were found to be affected by this alleged deficient practice. The Emergency Preparedness Plan will be reviewed by the facility. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** The Emergency Preparedness Plan will be reviewed by the facility. The Maintenance Director will be educated over the Emergency Preparedness Plan being reviewed annually. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** The Maintenance Director/Designee will monitor the Emergency Preparedness Plan	

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			monthly ongoing to ensure the plan is reviewed annually. 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.	
E 0013 SS=C Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk			

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	assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to,			

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	fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to update emergency preparedness policies and procedures annually. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's Emergency Preparedness Plan entitled "Emergency Preparedness Program" on 12/15/21 between 12:30 p.m. to 1:20 p.m. with the facility Acting Administrator and Maintenance Man present, documentation for policies and procedures reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan available had not been reviewed within the past 12 months with the last documented date of review being listed as 08/12/2019. Based on interview at the time of record review, the Acting Administrator said the facility has not had its emergency preparedness program reviewed by the facility within the most recent twelve-month period because the previous Administrator was no longer at this facility and she is currently in the role of Acting Administrator as of the time of this survey and had not yet had time to review or update the Emergency Preparedness Plan. During the exit conference with the Acting Administrator and the Maintenance Man at 3:25 p.m., no additional information or evidence could be provided contrary to this deficient finding.	E 0013	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** No residents were affected by this alleged deficient practice. The Emergency Preparedness policies and procedures will be reviewed by the facility. **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 have the potential to be affected, no other residents were found to be affected by this alleged deficient practice. The Emergency Preparedness policies and procedures will be reviewed by the facility. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** The Emergency Preparedness policies and procedures will be reviewed by the facility. The Maintenance Director will be educated over the Emergency Preparedness policies and	01/14/2022

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			procedures being reviewed annually. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** The Maintenance Director/Designee will monitor the Emergency Preparedness policies and procedures monthly ongoing to ensure the plan is reviewed annually. 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.	
E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities].			

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	Based on record review and interview, the facility failed to update an emergency preparedness communication plan that complies with Federal, State, and local laws in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan entitled "Emergency Preparedness Program" on 12/15/21 between 12:30 p.m. to 1:20 p.m. with the facility Acting Administrator and Maintenance Man present, documentation for a communication plan reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan available had not been reviewed within the past 12 months with the last documented date of review being listed as 08/12/2019. Based on interview at the time of record review, the Acting Administrator said the facility has not had its emergency preparedness program reviewed by the facility within the most recent twelve-month period because the previous Administrator was no longer at this facility and she is currently in the role of Acting Administrator as of the time of this survey and had not yet had time to review or update the Emergency Preparedness Plan. During the exit conference with the Acting Administrator and the Maintenance Man at 3:25 p.m., no additional information or evidence could be provided contrary to this deficient finding.	E 0029	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** No residents were affected by this alleged deficient practice. The Emergency Preparedness communication plan will be reviewed by the facility. **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 have the potential to be affected, no other residents were found to be affected by this alleged deficient practice. The Emergency Preparedness communication plan will be reviewed by the facility. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** The Emergency Preparedness communication plan will be reviewed by the facility. The Maintenance Director will be educated over the Emergency Preparedness communication plan being reviewed annually. **How The Corrective Action(s) Will Be Monitored To Ensure**	01/14/2022

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			The Deficient Practice Will Not Recur: The Maintenance Director/Designee will monitor the Emergency Preparedness communication plan monthly ongoing to ensure the plan is reviewed annually. 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.	
E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth			

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	in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The			

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	dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan entitled "Emergency Preparedness Program" on 12/15/21 between 12:30 p.m. to 1:20 p.m. with the facility Acting Administrator and Maintenance Man present, documentation for a training and testing program reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan available had not been reviewed within the past 12 months with the last documented date of review being listed as 08/12/2019. Based on interview at the time of record review, the Acting Administrator said the facility has not had its emergency preparedness program reviewed by the facility within the most recent twelve-month period because the previous Administrator was no longer at this facility and she is currently in the role of Acting Administrator as of the time of this survey and	E 0036	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** No residents were affected by this alleged deficient practice. The Emergency Preparedness training and testing program will be reviewed by the facility. **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 have the potential to be affected, no other residents were found to be affected by this alleged deficient practice. The Emergency Preparedness training and testing program will be reviewed by the facility. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient**	01/14/2022

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	had not yet had time to review or update the Emergency Preparedness Plan. During the exit conference with the Acting Administrator and the Maintenance Man at 3:25 p.m., no additional information or evidence could be provided contrary to this deficient finding.		**Practice Does Not Recur:** The Emergency Preparedness training and testing program will be reviewed by the facility. The Maintenance Director will be educated over the Emergency Preparedness training and testing program being reviewed annually. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** The Maintenance Director/Designee will monitor the Emergency Preparedness training and testing program monthly ongoing to ensure the plan is reviewed annually. 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.	
K 0000 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). Survey date: 12/15/21 Facility Number: 000288 Provider Number: 155743 AIM Number: 100287380	K 0000	This plan of correction is to serve as Greenhill Manor Nursing and Rehabilitation Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission of Greenhill Manor Nursing and Rehabilitation Center or its management company that the allegations	

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	At this Life Safety Code survey, Greenhill Manor. was found not in compliance with Requirements 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. The one-story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and hard-wired smoke detectors in resident sleeping rooms 33 through 45. All other resident rooms were equipped with battery powered smoke detectors. The facility has a capacity of 64 and had a census of 34 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 12/20/21		contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in the facility, nor does this submission constitute an agreement or admission of the survey allegations.	
K 0341 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at			

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	155743	A. BUILDING 01 B. WING	12/15/2021

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	notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 1) Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm panel was protected. NFPA 72, National Fire Alarm and Signaling Code Section 10.15 states in areas that are not continuously occupied, automatic smoke detection shall be provided at the location of each fire alarm control unit(s), notification appliance circuit power extenders, and supervising station transmitting equipment to provide notification of fire at that location. Exception: Where ambient conditions prohibit installation of automatic smoke detection, automatic heat detection shall be permitted. Annex A is not a part of the requirements but is included for informational purposes only. A.10.15 states the fire alarm control unit(s) that are to be protected are those that provide notification of a fire to the occupants and responders. The term fire alarm control unit does not include equipment such as annunciators and addressable devices. Requiring smoke detection at the transmitting equipment is intended to increase the probability that an alarm signal will be transmitted to a supervising station prior to that transmitting equipment being disabled due to the fire condition. CAUTION: The exception to 10.15 permits the use of a heat detector if ambient conditions are not suitable for smoke detection. It is important to also evaluate whether the area is suitable for the control unit. Where the area or room containing the control unit is provided with total smoke-detection coverage, additional smoke	K 0341	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** No residents were affected by this alleged deficient practice. A smoke detector will be placed in the closet containing the fire alarm panel that is located near the aviary. The fire alarm wire from the fire panel will be wired to a fully staffed nurse's station and tie into a new Silent Knight remote annunciator panel. **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 have the potential to be affected, no other residents were found to be affected by this alleged deficient practice. A smoke detector will be placed in the closet containing the fire alarm panel that is located near the aviary. The fire alarm wire from the fire panel will be wired to a fully staffed nurse's station and tie into a new Silent Knight remote annunciator panel.	01/14/2022

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	detection is not required to protect the control unit. Where total smoke-detection coverage is not provided, the Code intends that only one smoke detector is required at the control unit even when the area of the room would require more than one detector if installed according to the spacing rules in Chapter 17. The intent of selective coverage is to address the specific location of the equipment. Location of the required detection should be in accordance with one of the following: (1) Where the ceiling is 15 feet in height or less, the smoke detector should be located on the ceiling or the wall within 21 feet of the centerline of the fire alarm control unit being protected by the detector in accordance with 17.7.3.2.1. (2) Where the ceiling exceeds 15 feet in height, the automatic smoke detector should be installed on the wall above and within 6 feet from the top of the control unit. This deficient practice could affect all occupants. Findings include: Based on observation with the Maintenance man on 12/15/21 at 2:40 p.m., the fire alarm panel was located in the corridor enclosed in a closet near the aviary. This closet was not provided with a hard-wired smoke detector above the fire alarm panel. Based on an interview at the time of observation, the Maintenance man confirmed the aviary closet fire alarm panel was not continuously supervised and did not contain a smoke detector within the closet. During the exit conference with the Acting Administrator and the Maintenance Man at 3:25 p.m., no additional information or evidence could be provided contrary to this deficient finding.		**What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** A smoke detector will be placed in the closet containing the fire alarm panel that is located near the aviary. The fire alarm wire from the fire panel will be wired to a fully staffed nurse's station and tie into a new Silent Knight remote annunciator panel. The Maintenance Director will be educated over smoke detectors and the fire alarm panel requirements. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** The Maintenance Director/Designee will monitor smoke detectors and the fire alarm panel annunciator monthly times 6 months, then quarterly thereafter 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 minimum of 6 months and plan adjusted accordingly.	

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	3.1-19(b) 2) Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition. Section 10.12.5 states the trouble signal(s) shall be located in an area where it is likely to be heard. Section 10.7.1 states priority alarms, fire alarms, supervisory signals, and trouble signals shall be distinctively and descriptively annunciated. This deficient practice could affect all residents when occupied. Findings include: Based on observation with the Maintenance man on 12/15/21 at 2:40 p.m., the fire alarm panel was located in the corridor enclosed in a closet near the aviary. It was determined by testing that the panel trouble or supervisory signals would not be heard at the nearest nursing station (over 100 feet away) when tested. Based on an interview at the time of observation, the Maintenance man confirmed the aviary closet with the fire alarm panel inside was not continuously supervised and would not be heard during minimum staffing times within the facility. During the exit conference with the Acting Administrator and the Maintenance Man at 3:25 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)			
K 0511 SS=E	NFPA 101 Utilities - Gas and Electric			

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Bldg. 01	Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 3 ice machines were provided with a ground fault circuit interrupter (GFCI) protection against electric shock. LSC sections 9.1.2 requires all electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, Article 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, in 210.8(A), Dwelling Units, requires ground-fault circuit-interrupter (GFCI) protection for all personnel in bathrooms and kitchens where the receptacles are intended to serve the countertop surfaces. (7) Sinks - Located in areas other than kitchens where receptacles are installed within 1.8 m. (6 ft.) of the outside edge of the sink. This deficient practice affects as many as 14 residents, 2 staff and 1 visitor. Findings include: Based on observation with the Maintenance man on 12/15/21 at 2:28 p.m., the ice machine located within the clean utility area was not plugged into a protected G.F.C.I. outlet. When asked if the aforementioned outlet was GFCI protected, the Maintenance man stated that they were not. The Maintenance man acknowledged the receptacles in the clean utility area were not G.F.C.I. protected and were within six feet of a water source at the time of the observation. During the exit conference with the Acting	K 0511	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** No residents were affected by this alleged deficient practice. The ice machine outlet has been changed to a protected G.F.C.I outlet. **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 have the potential to be affected, no other residents were found to be affected by this alleged deficient practice. The ice machine outlet has been changed to a protected G.F.C.I outlet. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** The ice machine outlet has been changed to a protected G.F.C.I outlet. The Maintenance Director will be educated over the	01/14/2022

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	Administrator and the Maintenance Man at 3:25 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		requirements for G.F.C.I receptacles. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** The Maintenance Director/Designee will monitor areas requiring G.F.C.I receptacles weekly times 1 month, then every 2 weeks times 1 month, then monthly times 4 months, then quarterly thereafter 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 minimum of 6 months and plan adjusted accordingly.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to ensure 12 of 12 fire drills	K 0712	**What Corrective Action(s) Will Be Accomplished For Those**	01/14/2022

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	included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors. Findings include: Based on record review of the forms entitled "Chosen Healthcare Fire Drill Report" with the Maintenance man on 12/15/21 at 10:50 a.m., the fire drill forms for the 12 months lacked documentation of verification of transmission of the fire alarm signal to the monitoring station. The overnight or "silent drills" also lacked the verification of transmission of the fire alarm signal to the monitoring station the next day. Based on interview at the time of record review, the Maintenance man stated that he must have forgotten to document the time and names of the person he spoke with at the monitoring station for his drills, and that he would document that information on all future drills as applicable. During the exit conference with the Acting Administrator and the Maintenance Man at 3:25 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b) 3.1-51(c)		**Residents Found To Have Been Affected By The Deficient Practice:** No residents were affected by this alleged deficient practice. A fire drill will be conducted. **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 have the potential to be affected, no other residents were affected by this alleged deficient practice. A fire drill will be conducted. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** A fire drill will be conducted. Maintenance Director will be educated over Fire Drill Policy & Procedure & requirements. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** Maintenance Director/Designee will monitor the fire drill log monthly ongoing. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the	

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			QAPI committee monthly for minimum of 6 months and plan adjusted accordingly.	