PRINTED: 01/07/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING			COMPLETED	
		155743	B. WI	B. WING			12/15/2021	
			<u> </u>	CTREET	ADDRESS CITY STATE ZID CODE			
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE			
ODEENII	III I MANIOD				INCOLN AVE			
GREENH	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		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΤF	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
E 0000								
Bldg								
	An Emergency Pre	paredness Survey was	E 00	000	This plan of correction is to se	rve		
	conducted by the Ir	ndiana Department of Health			as Greenhill Manor Nursing ar	nd		
	in accordance with	42 CFR 483.73.			Rehabilitation Center's credible	е		
					allegation of compliance.			
	Survey Date: 12/1:	5/21			Submission of this plan of			
					correction does not constitute	an		
	Facility Number: (000288			admission of Greenhill Manor			
	Provider Number:	155743			Nursing and Rehabilitation			
	AIM Number: 100	287380			Center or its management			
					company that the allegations			
	At this Emergency	Preparedness survey,			contained in the survey report	are		
	Greenhill Manor w	as found in substantial			a true and accurate portrayal o	of		
	compliance with E	mergency Preparedness			the provision of nursing care a	nd		
	Requirements for N	Medicare and Medicaid			other services in the facility, no	or		
	Participating Provide	ders and Suppliers, 42 CFR			does this submission constitut	e an		
	483.73				agreement or admission of the	:		
					survey allegations.			
	The facility has 64	certified beds. At the time of						
	the survey, the cens	sus was 34.						
	Quality Review con	mpleted on 12/20/21						
E 0004	403.748(a), 416.5	* *						
SS=C	441.184(a), 482.1							
Bldg	483.73(a), 484.10	, ,						
	485.68(a), 485.72							
	486.360(a), 491.1	2(a), 494.62(a)						
	Develop EP Plan,	Review and Update						
	Annually							
	§403.748(a), §410	6.54(a), §418.113(a),						
	§441.184(a), §460	0.84(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), §480	6.360(a), §491.12(a),						
	§494.62(a).							
	The [facility] must	comply with all applicable						
			1					

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.

000288

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	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155743	B. WING		12/15/	/2021
	PROVIDER OR SUPPLIER	<u> </u>	501 N	T ADDRESS, CITY, STATE, ZIP CODE I LINCOLN AVE LER, IN 47944		
(X4) ID PREFIX	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI.	ATE	(X5) COMPLETION
TAG	Federal, State and preparedness req must develop esta comprehensive er program that mee section. The emer program must include the following elem (a) Emergency Pladevelop and main preparedness planand updated at least must do all of the "[For hospitals at §485.625(a):] Emergency Planat develop and main preparedness req CAH] must develoc comprehensive er program that mee section, utilizing a "[For LTC Facilitie Emergency Planat develop and main preparedness planand updated at least "[For ESRD Facil Emergency Planat develop and main preparedness planand updated at least "Incomprehensis planat updated at least "Incomprehens planat "Inc	an. The [facility] must tain an emergency in that must be [reviewed], ast every 2 years. The plan following: §482.15 and CAHs at ergency Plan. The [hospital apply with all applicable d local emergency uirements. The [hospital or apply and maintain a mergency preparedness ts the requirements of this in all-hazards approach. Les at §483.73(a):] The LTC facility must tain an emergency in that must be reviewed, ast annually. Ities at §494.62(a):] The ESRD facility must tain an emergency in that must be [evaluated], ast every 2 years.	TAG	DEFICIENCY)		DATE
		view and interview, the velop and maintain an	E 0004	What Corrective Action(s) W Be Accomplished For Those		01/14/2022

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Event ID:

KTS721 Facility ID: 000288

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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 COMPLETED			ETED	
		155743	B. W	ING		12/15/2	2021
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
					INCOLN AVE		
GREENH	HILL MANOR			FOWLE	ER, IN 47944		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE	DATE
	emergency prepare	edness plan that was reviewed			Residents Found To Have Be	en	
		st annually in accordance with			Affected By The Deficient		
	•	This deficient practice could			Practice:		
	affect all occupants	-			No residents were affected by	this	
	arreet an occupants	3.			alleged deficient practice. The		
	Findings include:				Emergency Preparedness Pla		
	rindings include.				will be reviewed by the facility.		
	Dagad on marriage of	f the facility's Emergency			will be reviewed by the facility.		
		entitled "Emergency			How Other Besidents Having		
	_	ram" on 12/15/21 between			How Other Residents Having The Potential To Be Affected		
						БУ	
	_	p.m. with the facility Acting			The Same Deficient Practice		
	_	ent, documentation for an			Will Be Identified And What		
		edness program reviewed by			Corrective Action(s) Will Be		
	-	the most recent twelve-month			Taken:		
	_	ilable for review. The			All residents have the potentia		
		ailable had not been reviewed			be affected, no other residents		
	_	months with the last			were found to be affected by the		
		of review being listed as			alleged deficient practice. The		
		on interview at the time of			Emergency Preparedness Pla		
		Acting Administrator said the			will be reviewed by the facility.		
	-	l its emergency preparedness					
		by the facility within the most			What Measures Will Be Put Ir	ıto	
		th period because the previous			Place and What Systemic		
		o longer at this facility and the			Changes Will Be Made To		
		arrently in the role of Acting			Ensure That The Deficient		
		f the time of this survey so had			Practice Does Not Recur:		
		review or update the			The Emergency Preparedness	3	
		edness Plan. During the exit			Plan will be reviewed by the		
		e Acting Administrator and the			facility. The Maintenance Direct	ctor	
		at 3:25 p.m., no additional			will be educated over the		
		dence could be provided			Emergency Preparedness Pla	n	
	contrary to this def	ficient finding.			being reviewed annually.		
					How The Corrective Action(s	-	
					Will Be Monitored To Ensure		
					The Deficient Practice Will No	ot	
					Recur:		
					The Maintenance		
					Director/Designee will monitor	the	
					Emergency Preparedness Pla	n	

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Event ID:

KTS721

Facility ID: 000288

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155743		A. BUILDING	nstruction 	COMPI	LETED
	155743	B. WING	DDDECC CITY CTATE ZID CON		/2021
	PROVIDER OR SUPPLIER HILL MANOR	501 N LI	ddress, city, state, zip codi INCOLN AVE R, IN 47944	3	
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION D BE OPRIATE	(X5) COMPLETION DATE
			monthly ongoing to ensure plan is reviewed annually negative findings will be commediately and forwards Administrator. A report of progress will be forwarded QAPI committee monthly minimum of 6 months and adjusted accordingly.	Any orrected d to the d to the for	
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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING		COMPL	ETED
		155743	B. W	ING		12/15/	2021
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			INCOLN AVE		
CDEENIL	HILL MANOR				R, IN 47944		
GNEENI	IILL WANON			FOWLE	.r., in 47 944		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES ID		PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	G DEFICIENCY)		DATE
	assessment at pa	ragraph (a)(1) of this					
	section, and the c	ommunication plan at					
		his section. The policies					
	· ·	nust be reviewed and					
	updated at least a	innually.					
		rements for PACE and					
	ESRD Facilities:						
	*IE - * DAOE - + 0.4*	CO 04/h):1 Daliaia!					
	_	60.84(b):] Policies and					
	l ·	PACE organization must					
	develop and imple						
		icies and procedures,					
	paragraph (a) of t	ergency plan set forth in					
	1	ragraph (a)(1) of this					
		ommunication plan at					
		his section. The policies					
	1	nust address management					
		nmedical emergencies,					
		limited to: Fire; equipment,					
	I -	ailure; care-related					
	1 ·	I natural disasters likely to					
	threaten the healt	-					
		or the public. The policies					
		nust be reviewed and					
	updated at least e						
	'	, ,					
	*[For ESRD Facili	ties at §494.62(b):]					
	_	edures. The dialysis					
	1	op and implement					
	emergency prepa	redness policies and					
	procedures, base	d on the emergency plan					
	set forth in paragr	aph (a) of this section, risk					
	assessment at pa	ragraph (a)(1) of this					
	section, and the c	ommunication plan at					
	paragraph (c) of the	his section. The policies					
	and procedures m	nust be reviewed and					
	updated at least e	every 2 years. These					
	emergencies inclu	ıde, but are not limited to,					

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Event ID:

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING		COMPL	ETED
		155743	B. W	NG		12/15/	2021
				CED FEE	ADDRESS STEV STATE STE SODE		-
NAME OF P	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
					INCOLN AVE		
GREENH	HILL MANOR			FOWLE	ER, IN 47944		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWINED'S BLANCE CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
	fire, equipment or	power failures,					
		gencies, water supply					
		natural disasters likely to					
	1	y's geographic area.					
	•	view and interview, the	E 0)13	What Corrective Action(s) W	ill	01/14/2022
	facility failed to upo	date emergency preparedness			Be Accomplished For Those		
		ures annually. The policies			Residents Found To Have Be	en	
		st be reviewed and updated at			Affected By The Deficient		
	_	cordance with 42 CFR			Practice:		
	· ·	icient practice could affect			No residents were affected by	this	
	all residents in the f	-			alleged deficient practice. The		
		•			Emergency Preparedness		
	Findings include:				policies and procedures will be	9	
					reviewed by the facility.		
	Based on review of	the facility's Emergency					
	Preparedness Plan	entitled "Emergency			How Other Residents Having	ı	
	Preparedness Progr	am" on 12/15/21 between			The Potential To Be Affected	Ву	
	12:30 p.m. to 1:20 p	p.m. with the facility Acting			The Same Deficient Practice		
	Administrator and I	Maintenance Man present,			Will Be Identified And What		
	documentation for p	policies and procedures			Corrective Action(s) Will Be		
	reviewed by the fac	ility within the most recent			Taken:		
	twelve-month perio	d was not available for			All residents have the potentia	l to	
	review. The emerge	ency plan available had not			be affected, no other residents	3	
	been reviewed with	in the past 12 months with the			were found to be affected by t	his	
	last documented da	te of review being listed as			alleged deficient practice. The		
	08/12/2019. Based	on interview at the time of			Emergency Preparedness		
		Acting Administrator said the			policies and procedures will be	9	
		its emergency preparedness			reviewed by the facility.		
	1	by the facility within the most					
	recent twelve-mont	h period because the previous			What Measures Will Be Put II	nto	
		no longer at this facility and			Place and What Systemic		
	she is currently in the				Changes Will Be Made To		
		the time of this survey and			Ensure That The Deficient		
	I	e to review or update the			Practice Does Not Recur:		
		edness Plan. During the exit			The Emergency Preparedness		
		Acting Administrator and the			policies and procedures will be	9	
		at 3:25 p.m., no additional			reviewed by the facility. The		
		ence could be provided			Maintenance Director will be		
	contrary to this defi	icient finding.			educated over the Emergency	'	
					Preparedness policies and		

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155743	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION	(X3) DATE SURVEY COMPLETED 12/15/2021	
	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 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
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].		procedures being reviewed annually. How The Corrective Action(s Will Be Monitored To Ensure The Deficient Practice Will Necur: The Maintenance Director/Designee will monitor Emergency Preparedness policies and procedures montongoing to ensure the plan is reviewed annually. Any negatifindings will be corrected immediately and forwarded to Administrator. A report of progress will be forwarded to QAPI committee monthly for minimum of 6 months and plate adjusted accordingly.	r the hly ive the the	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155743	r í	JILDING	ONSTRUCTION	(X3) DATE S COMPL 12/15/	ETED
	PROVIDER OR SUPPLIER			501 N L	ADDRESS, CITY, STATE, ZIP CODE LINCOLN AVE ER, 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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	facility failed to uppreparedness common with Federal, State, with 42 CFR 483.75 could affect all occurs affect all occurs findings include: Based on review of Preparedness Plant of Preparedness Programs 12:30 p.m. to 1:20 p. Administrator and Macumentation for a reviewed by the fact twelve-month perior review. The emergency been reviewed with last documented day 08/12/2019. Based record review, the Afacility has not had program reviewed by recent twelve-month Administrator was as he is currently in the Administrator as of had not yet had time Emergency Prepare conference with the Maintenance Man and street and street many conference with the Maintenance Man and street and street many conference with the Maintenance Man and street and street many conference with the Maintenance Man and street and street many conference with the Maintenance Man and street and street many conference with the Maintenance Man and street many conference with th	and local laws in accordance accordance. This deficient practice apants. If the facility's Emergency entitled "Emergency am" on 12/15/21 between form, with the facility Acting Maintenance Man present, a communication plan and ility within the most recent down was not available for ency plan available had not in the past 12 months with the tee of review being listed as non interview at the time of Acting Administrator said the its emergency preparedness by the facility within the most his period because the previous no longer at this facility and the role of Acting at the time of this survey and the to review or update the dness Plan. During the exit at 3:25 p.m., no additional ence could be provided	E 00	029	What Corrective Action(s) W Be Accomplished For Those Residents Found To Have Be Affected By The Deficient Practice: No residents were affected by alleged deficient practice. The Emergency Preparedness communication plan will be reviewed by the facility. How Other Residents Having The Potential To Be Affected The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken: All residents have the potentia be affected, no other residents were found to be affected by t alleged deficient practice. The Emergency Preparedness communication plan will be reviewed by the facility. What Measures Will Be Put In 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	this By I by	01/14/2022

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING		COMPLETED
		155743	_		12/15/2021
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
GREENH	HILL MANOR			LINCOLN AVE LER, IN 47944	
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
	`	CY MUST BE PRECEDED BY FULL		CROSS-REFERENCED TO THE APPROPRIA	TE
E 0036 SS=C Bldg	403.748(d), 416.54 441.184(d), 482.13 483.73(d), 484.102 485.68(d), 485.72 486.360(d), 491.12 EP Training and T §403.748(d), §446 §441.184(d), §460 §483.73(d), §485.6 §485.920(d), §486 §494.62(d). *[For RNCHIs at § §416.54, Hospice §441.184, PACE at §481.184, PACE at §482.15, HHAs at §485.68, CAHs at under 485.727, CN at §486.360, and F Training and testing develop and maint preparedness train	4(d), 418.113(d), 5(d), 483.475(d), 2(d), 485.625(d), 7(d), 485.920(d), 2(d), 494.62(d) esting 5.54(d), §418.113(d), 9.84(d), §482.15(d), 475(d), §484.102(d), 525(d), §485.727(d), 5.360(d), §491.12(d), 9.360(d), §491.12(d), 9.360(d), 9.	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE	ot the the the

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KTS721

Facility ID: 000288

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		INSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING 'ING			
		155743	D. W		<u> </u>	12/15/	/2021
NAME OF F	PROVIDER OR SUPPLIEF	₹		1	ADDRESS, CITY, STATE, ZIP CODE		
					INCOLN AVE		
GREENF	HILL MANOR			FOWLE	R, IN 47944		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		of this section, risk					
		ragraph (a)(1) of this					
	section, policies a	nd procedures at his section, and the					
		an at paragraph (c) of this					
		ing and testing program					
		and updated at least every					
	2 years.	,					
	-	s at §483.73(d):] (d)					
	_	ng. The LTC facility must					
	1	tain an emergency					
		ning and testing program ne emergency plan set forth					
	in paragraph (a) o	.					
	. • ,	ragraph (a)(1) of this					
	section, policies a						
	I -	his section, and the					
	communication pl	an at paragraph (c) of this					
		ing and testing program					
		and updated at least					
	annually.						
	*IFor ICE/IIDo ot 9	2492 475/d):1 Training and					
		§483.475(d):] Training and ID must develop and					
		gency preparedness					
		g program that is based on					
	_	an set forth in paragraph					
	(a) of this section,	risk assessment at					
	paragraph (a)(1)	of this section, policies and					
		agraph (b) of this section,					
		cation plan at paragraph (c)					
		ne training and testing					
		reviewed and updated at rs. The ICF/IID must meet					
	1	for evacuation drills and					
	training at §483.4						
	3 3 61	· ·					
	*[For ESRD Facili	ties at §494.62(d):]					
	Training, testing, a	and orientation. The					
	1		1				1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING		COMPL	ETED
		155743	B. W	ING		12/15/	/2021
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	₹			INCOLN AVE		
GREEN	HILL MANOR				ER, IN 47944		
(X4) ID	CHMMADVC	TATEMENT OF DEFICIENCIES	1	ID	, T		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LISC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1710		ust develop and maintain an		1710			DATE
	, , ,	redness training, testing					
		ation program that is based					
		/ plan set forth in paragraph					
		, risk assessment at					
		of this section, policies and					
		agraph (b) of this section,					
		cation plan at paragraph (c)					
		ne training, testing and					
	orientation progra	m must be evaluated and					
	updated at every	2 years.					
		view and interview, the	E 0	036	What Corrective Action(s) W		01/14/2022
		velop and maintain an			Be Accomplished For Those		
		dness training and testing			Residents Found To Have Be	en	
		eviewed and updated at least			Affected By The Deficient		
		ance with 42 CFR 483.73(d).			Practice:		
	This deficient pract	ice could affect all			No residents were affected by		
	occupants.				alleged deficient practice. The		
	Findings in ded.				Emergency Preparedness trai	ning	
	Findings include:				and testing program will be reviewed by the facility.		
	Raced on review of	the facility's Emergency			l reviewed by the facility.		
		entitled "Emergency			How Other Residents Having	ı	
	-	ram" on 12/15/21 between			The Potential To Be Affected		
		p.m. with the facility Acting			The Same Deficient Practice	-,	
		Maintenance Man present,			Will Be Identified And What		
		a training and testing program			Corrective Action(s) Will Be		
		cility within the most recent			Taken:		
	· ·	od was not available for			All residents have the potentia	l to	
	review. The emerge	ency plan available had not			be affected, no other residents	3	
		in the past 12 months with the			were found to be affected by t		
		te of review being listed as			alleged deficient practice. The		
		on interview at the time of			Emergency Preparedness trai	ning	
		Acting Administrator said the			and testing program will be		
		its emergency preparedness			reviewed by the facility.		
		by the facility within the most			Milest Manager 1871 B. B. C.	-4-	
		h period because the previous			What Measures Will Be Put In	nto	
		no longer at this facility and			Place and What Systemic		
	she is currently in t	——————————————————————————————————————			Changes Will Be Made To Ensure That The Deficient		
	Administrator as of	the time of this survey and			Ensure mat me Deficient		

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	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		UNSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		155743	B. WING		12/15/2021
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
				LINCOLN AVE	
GREENH	IILL MANOR		FOWLE	ER, IN 47944	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE	E COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		e to review or update the		Practice Does Not Recur:	
		dness Plan. During the exit		The Emergency Preparedne	
		Acting Administrator and the		training and testing program	
		t 3:25 p.m., no additional		be reviewed by the facility. T	
		ence could be provided		Maintenance Director will be	
	contrary to this defic	cient finding.		educated over the Emergend	-
				Preparedness training and to program being reviewed ann	-
				program being reviewed and	iuany.
				How The Corrective Action	(s)
				Will Be Monitored To Ensur	` '
				The Deficient Practice Will	Not
				Recur:	
				The Maintenance	
				Director/Designee will monite	or the
				Emergency Preparedness tr	_
				and testing program monthly	
				ongoing to ensure the plan is	
				reviewed annually. Any nega	ative
				findings will be corrected	
				immediately and forwarded t	o the
				Administrator. A report of	41
				progress will be forwarded to	
				QAPI committee monthly for minimum of 6 months and pl	
				adjusted accordingly.	all
				aujustou accordingry.	
K 0000					
Bldg. 01	ATIC C.C. C.	D ('C' (' 10')	TT 0000	This when of a sure sties is t	
	•	Recertification and State	K 0000	This plan of correction is to sas Greenhill Manor Nursing	
	_	as conducted by the Indiana th in accordance with 42		Rehabilitation Center's credi	
	CFR 483.90(a).	in in accordance with 42		allegation of compliance.	DIC
	CI IC 705.70(a).			Submission of this plan of	
	Survey date: 12/15/	/21		correction does not constitut	
	Essilie N. 1 O	00200		admission of Greenhill Mand	or
	Facility Number: 0			Nursing and Rehabilitation	
	Provider Number: 1002			Center or its management	,
	Alivi Number: 1002	20/300		company that the allegations	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				INSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	01	COMPL	
		155743	B. W.	ING		12/15/	/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					INCOLN AVE		
GREENH	IILL MANOR			FOWLE	R, IN 47944		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
					contained in the survey report		
	-	Code survey, Greenhill			a true and accurate portrayal o		
		ot in compliance with			the provision of nursing care a		
	Requirements for Pa	_			other services in the facility, no		
		, 42 CFR Subpart 483.90(a),			does this submission constitut		
	-	re, and the 2012 edition of			agreement or admission of the	:	
		otection Association (NFPA)			survey allegations.		
	-	de (LSC), Chapter 19, e Occupancies and 410 IAC					
	16.2.	e Occupancies and 410 IAC					
	10.2.						
	The one-story facili	ty was determined to be of					
	-	ruction and was fully					
	sprinklered. The fac	ility has a fire alarm system					
	with smoke detection	n in the corridors, spaces					
	open to the corridor	s and hard-wired smoke					
		sleeping rooms 33 through					
		nt rooms were equipped with					
		oke detectors. The facility					
		and had a census of 34 at the					
	time of this survey.						
	All areas where the	residents have customary					
		ered and all areas providing					
	facility services wer						
	•	•					
	Quality Review con	npleted on 12/20/21					
K 0341	NFPA 101						
SS=F	Fire Alarm System	ı - Installation					
Bldg. 01	Fire Alarm System						
5	•	n is installed with systems					
	-	approved for the purpose in					
	accordance with N	IFPA 70, National Electric					
	Code, and NFPA	72, National Fire Alarm					
		fective warning of fire in					
	any part of the bui	•					
		pied, detection is installed					
		control unit. In new					
	occupancy, detect	ion is also installed at					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFIC		IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>01</u>		COMPLETED		
		155743	B. W	NG	<u> </u>		/2021	
				CENTER	DDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER	t						
					INCOLN AVE			
GREENHILL MANOR			FOWLE	ER, IN 47944				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		DROWIDERIC DI AM OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T-	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	16	DATE	
	notification appliar	nce circuit power						
	extenders, and su							
		ment. Fire alarm system						
		nsmission paths are						
	monitored for integ							
	18.3.4.1, 19.3.4.1							
	ł	ation and interview, the	K 0	341	What Corrective Action(s) W	ill	01/14/2022	
		sure 1 of 1 fire alarm panel			Be Accomplished For Those			
	1	PA 72, National Fire Alarm			Residents Found To Have Be	en		
	and Signaling Code	Section 10.15 states in areas			Affected By The Deficient			
		ously occupied, automatic			Practice:			
	smoke detection sha	all be provided at the location			No residents were affected by	this		
	of each fire alarm c	ontrol unit(s), notification			alleged deficient practice. A			
	appliance circuit po	ower extenders, and			smoke detector will be placed	in		
	supervising station	transmitting equipment to			the closet containing the fire a	larm		
	provide notification	of fire at that location.			panel that is located near the			
	Exception: Where a	ambient conditions prohibit			aviary. The fire alarm wire fror	n		
	installation of autor	natic smoke detection,			the fire panel will be wired to a	1		
	automatic heat dete	ction shall be permitted.			fully staffed nurse's station and	d tie		
					into a new Silent Knight remot	е		
	Annex A is not a pa	art of the requirements but is			annunciator panel.			
	included for inform	ational purposes only.						
	A.10.15 states the f	ire alarm control unit(s) that			How Other Residents Having	l		
	are to be protected a	are those that provide			The Potential To Be Affected	Ву		
	notification of a fire	e to the occupants and			The Same Deficient Practice			
	responders. The terr	m fire alarm control unit does			Will Be Identified And What			
	not include equipme	ent such as annunciators and			Corrective Action(s) Will Be			
	addressable devices	s. Requiring smoke detection			Taken:			
	at the transmitting e	equipment is intended to			All residents have the potentia	l to		
	_	ility that an alarm signal will			be affected, no other residents			
		supervising station prior to			were found to be affected by the	his		
	that transmitting eq	uipment being disabled due to			alleged deficient practice. A			
	the fire condition.				smoke detector will be placed			
		ception to 10.15 permits the			the closet containing the fire a	larm		
		or if ambient conditions are			panel that is located near the			
		oke detection. It is important			aviary. The fire alarm wire fror			
		ether the area is suitable for			the fire panel will be wired to a			
		nere the area or room			fully staffed nurse's station and			
		rol unit is provided with total			into a new Silent Knight remot	е		
	smoke-detection co	verage, additional smoke			annunciator panel.			

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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. BU	JILDING	01	COMPL	ETED
		155743	B. W	B. WING		12/15/	2021
		1007.10				12/10/	2021
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TO HAIL OF T	NO VIDER OR SOLVEIER			501 N L	INCOLN AVE		
GREENH	IILL MANOR			FOWLE	ER, IN 47944		
OVA ID	CID D () DV C	TA THE MENT OF DEPLOYED LOTTE	1		· 		07.5
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	detection is not requ	aired to protect the control					
	unit. Where				What Measures Will Be Put Ir	nto	
	total smoke-detection	on coverage is not provided,			Place and What Systemic		
		at only one smoke detector is			Changes Will Be Made To		
		rol unit even when the area of			Ensure That The Deficient		
	_	uire more than one detector			Practice Does Not Recur:		
	-					d in	
		g to the spacing rules in			A smoke detector will be place		
	-	ent of selective coverage is to			the closet containing the fire al	ıarm	
	_	location of the equipment.			panel that is located near the		
	_	aired detection should be in			aviary. The fire alarm wire fron		
	accordance with one				the fire panel will be wired to a		
	(1) Where the ceilin	g is 15 feet in height or less,			fully staffed nurse's station and	d tie	
	the smoke detector	should be located on the			into a new Silent Knight remote	e	
	ceiling or the wall v	vithin 21 feet of the			annunciator panel. The		
	-	e alarm control unit being			Maintenance Director will be		
		ector in accordance with			educated over smoke detector	s	
	17.7.3.2.1.				and the fire alarm panel		
		ig exceeds 15 feet in height,			requirements.		
	* *	e detector should be installed			requirements.		
					How The Corrective Action(s	、 I	
		nd within 6 feet from the top			How The Corrective Action(s	·	
	of the control unit.				Will Be Monitored To Ensure		
	This deficient pract	ice could affect all			The Deficient Practice Will No	ot	
	occupants.				Recur:		
					The Maintenance		
	Findings include:				Director/Designee will monitor		
					smoke detectors and the fire		
	Based on observation	on with the Maintenance man			alarm panel annunciator montl	hly	
	on 12/15/21 at 2:40	p.m., the fire alarm panel			times 6 months, then quarterly	,	
		orridor enclosed in a closet			thereafter to ensure continued		
		s closet was not provided with			compliance. Any negative findi		
		detector above the fire alarm			will be corrected immediately a	-	
		interview at the time of			forwarded to the Administrator		
	-	intenance man confirmed the			report of progress will be		
	·				forwarded to the QAPI commit	_{too}	
	aviary closet fire ala	-					
		vised and did not contain a			monthly for minimum of 6 mon		
		nin the closet. During the exit			and plan adjusted accordingly.	.	
		Acting Administrator and the					
		t 3:25 p.m., no additional					
	information or evidence	ence could be provided					
	contrary to this defi	cient finding.					
			1		İ		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. Bl	JILDING	01	COMPL	ETED	
		155743	B. W			12/15/	/2021
NAME OF I	PROVIDER OR SUPPLIEF	R			DDRESS, CITY, STATE, ZIP CODE		
GREENH	HILL MANOR				INCOLN AVE R, IN 47944		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	COMPLETION DATE
TAG	REGULATORT OR	LESC IDENTIF TING INFORMATION)	+	TAG	BEITELENETY		DATE
	3.1-19(b)						
	facility failed to ma systems in accordar Fire Alarm and Sig Section 10.12.5 stat be located in an are heard. Section 10.7.1 state supervisory signals distinctively and de	ation and interview, the sintain 1 of 1 fire alarm nee with NFPA 72, National naling Code, 2010 Edition. tes the trouble signal(s) shall a where it is likely to be as priority alarms, fire alarms, and trouble signals shall be escriptively annunciated. This could affect all residents when					
	Findings include:						
	on 12/15/21 at 2:40 was located in the conear the aviary. It was the panel trouble or not be heard at the panel trouble or not be panel to the panel trouble or not be heard at the panel trouble or not pane	on with the Maintenance man p.m., the fire alarm panel corridor enclosed in a closet was determined by testing that a supervisory signals would mearest nursing station (over an tested. Based on an are of observation, the confirmed the aviary closet panel inside was not wised and would not be heard affing times within the exit conference with the or and the Maintenance Man ditional information or provided contrary to this					
	3.1-19(b)						
K 0511 SS=E	NFPA 101 Utilities - Gas and	Electric					

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 CO.		COMPL	COMPLETED			
		155743	B. WI	NG	12/		2021
				CED FEE	A DDDDGG GUTY GTATE JID GODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ODEENII	W. I. MANIOD				LINCOLN AVE		
GREENHILL MANOR			FOWLE	ER, IN 47944			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
Bldg. 01	Utilities - Gas and	Electric					
	Equipment using g	gas or related gas piping					
	complies with NFF	PA 54, National Fuel Gas					
	Code, electrical wi	ring and equipment					
	complies with NFF	PA 70, National Electric					
	Code. Existing ins	tallations can continue in					
	service provided n	o hazard to life.					
	18.5.1.1, 19.5.1.1,	9.1.1, 9.1.2					
	Based on observation	on and interview, the facility	K 0	511	What Corrective Action(s) Wi	ill	01/14/2022
	failed to ensure 1 of	3 ice machines were			Be Accomplished For Those		
	provided with a grow	und fault circuit interrupter			Residents Found To Have Be	en	
	(GFCI) protection a	gainst electric shock. LSC			Affected By The Deficient		
	sections 9.1.2 requir	res all electrical wiring and			Practice:		
	equipment shall be i	in accordance with NFPA 70,			No residents were affected by	this	
	National Electrical (Code. NFPA 70, Article			alleged deficient practice. The	ice	
	210.8 Ground-Fault	Circuit-Interrupter			machine outlet has been chan	ged	
		nnel, in 210.8(A), Dwelling			to a protected G.F.C.I outlet.		
		nd-fault circuit-interrupter					
		or all personnel in bathrooms			How Other Residents Having		
		the receptacles are intended			The Potential To Be Affected	Ву	
		top surfaces. (7) Sinks -			The Same Deficient Practice		
		er than kitchens where			Will Be Identified And What		
		illed within 1.8 m. (6 ft.) of			Corrective Action(s) Will Be		
	_	the sink. This deficient			Taken:		
	-	nany as 14 residents, 2 staff			All residents have the potentia		
	and 1 visitor.				be affected, no other residents		
					were found to be affected by the		
	Findings include:				alleged deficient practice. The		
					machine outlet has been chan	ged	
		on with the Maintenance man			to a protected G.F.C.I outlet.		
		p.m., the ice machine					
		lean utility area was not			What Measures Will Be Put Ir	ito	
		ected G.F.C.I. outlet. When			Place and What Systemic		
		entioned outlet was GFCI			Changes Will Be Made To		
	-	tenance man stated that they			Ensure That The Deficient		
		tenance man acknowledged			Practice Does Not Recur:		
	•	e clean utility area were not			The ice machine outlet has be		
	-	nd were within six feet of a			changed to a protected G.F.C.		
		time of the observation.			outlet. The Maintenance Direc	tor	
	During the exit conf	ference with the Acting			will be educated over the		

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155743	A. BUILDING B. WING	01	COMPLETED 12/15/2021
		100140			12/13/2021
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
GREENL	IILL MANOR			LINCOLN AVE ER, IN 47944	
		EATEMENT OF DEPLOYENCIES		_	(775)
(X4) ID PREFIX		CATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION
TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE DATE
1110		he Maintenance Man at 3:25	1110	requirements for G.F.C.I	BITE
	p.m., no additional i	information or evidence could		receptacles.	
	be provided contrar	y to this deficient finding.			
				How The Corrective Action(•
	3.1-19(b)			Will Be Monitored To Ensur	
				The Deficient Practice Will Necur:	Not
				The Maintenance	
				Director/Designee will monito	or
				areas requiring G.F.C.I	
				receptacles weekly times 1 m	nonth,
				then every 2 weeks times 1	
				month, then monthly times 4 months, then quarterly therea	ofter
				to ensure continued compliar	
				Any negative findings will be	100.
				corrected immediately and	
				forwarded to the Administrate	or. A
				report of progress will be	
				forwarded to the QAPI comm	
				monthly for minimum of 6 mo and plan adjusted accordingly	
				and plan adjusted according	y.
K 0712	NFPA 101				
SS=F	Fire Drills				
Bldg. 01	Fire Drills				
		he transmission of a fire			
	fire conditions. Fire	imulation of emergency e drills are held at			
		xpected times under			
	•	, at least quarterly on each			
	shift. The staff is fa	amiliar with procedures			
		drills are part of established			
		ills are conducted between			
	9:00 PM and 6:00	AM, a coded ay be used instead of			
	audible alarms.	ay be used ilistedu Ul			
	19.7.1.4 through 1	9.7.1.7			
	•	riew and interview, the	K 0712	What Corrective Action(s) V	ViII 01/14/2022
	facility failed to ens	ure 12 of 12 fire drills		Be Accomplished For Those	
			1		l

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KTS721

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SU		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
i '		IDENTIFICATION NUMBER:	A. B	UILDING	01	COMPLETED	
		155743	B. W	ING		12/15/2021	
				CTREET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
OBEEN					INCOLN AVE		
GREENHILL MANOR				FOWLE	ER, IN 47944		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DDOVIDED'S DI AN OE CODDECTION	(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)	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	included the verifica	ation of transmission of the			Residents Found To Have Be	een	
	fire alarm signal to	the monitoring station in fire			Affected By The Deficient		
	drills conducted bet	ween 6:00 a.m. and 9:00 p.m.			Practice:		
	for the last 4 quarter	rs. LSC 19.7.1.4 requires fire			No residents were affected by	this	
	drills in health care	occupancies shall include the			alleged deficient practice. A fir	re l	
		e alarm signal and simulation			drill will be conducted.		
		onditions. This deficient					
		esidents in the facility as			How Other Residents Having	ı	
	well as staff and vis				The Potential To Be Affected		
					The Same Deficient Practice		
	Findings include:				Will Be Identified And What		
					Corrective Action(s) Will Be		
	Based on record rev	view of the forms entitled			Taken:		
	"Chosen Healthcare	Fire Drill Report" with the			All residents have the potentia	al to	
		n 12/15/21 at 10:50 a.m., the			be affected, no other residents		
	fire drill forms for t	he 12 months lacked			were affected by this alleged		
	documentation of ve	erification of transmission of			deficient practice. A fire drill w	ill	
	the fire alarm signal	to the monitoring station.			be conducted.		
	The overnight or "si	ilent drills" also lacked the					
	verification of trans	mission of the fire alarm			What Measures Will Be Put I	nto	
	signal to the monito	ring station the next day.			Place and What Systemic		
	Based on interview	at the time of record review,			Changes Will Be Made To		
	the Maintenance ma	an stated that he must have			Ensure That The Deficient		
	forgotten to docume	ent the time and names of the			Practice Does Not Recur:		
	person he spoke wit	th at the monitoring station			A fire drill will be conducted.		
	for his drills, and th	at he would document that			Maintenance Director will be		
	information on all f	uture drills as applicable.			educated over Fire Drill Policy	. &	
	During the exit cont	ference with the Acting			Procedure & requirements.		
	Administrator and t	he Maintenance Man at 3:25					
	p.m., no additional	information or evidence could			How The Corrective Action(s	5)	
	be provided contrar	y to this deficient finding.			Will Be Monitored To Ensure		
					The Deficient Practice Will N	ot	
	3.1-19(b)				Recur:		
	3.1-51(c)				Maintenance Director/Designe	ee	
					will monitor the fire drill log		
					monthly ongoing. Any negative	e	
					findings will be corrected		
					immediately and forwarded to	the	
					Administrator. A report of		
					progress will be forwarded to t	the	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 01			COMPLETED	
		155743	B. WI	NG		12/15/	/2021	
	PROVIDER OR SUPPLIE	R		501 N L	ADDRESS, CITY, STATE, ZIP CODE LINCOLN AVE ER, IN 47944			
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	
					QAPI committee monthly for minimum of 6 months and plar adjusted accordingly.	1		

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