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	03/28/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/28/23 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 26. Quality Review completed on 03/30/23	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 0015 SS=C Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), 485.625(b)(1) Subsistence Needs for Staff and Patients §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kiri Burks	Administrator	04/12/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm			

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	systems. (C) Sewage and waste disposal. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants. Findings include: Based on record review with the facility Administrator and the Maintenance Director on 03/28/23 at 1:41 p.m., the facility was unable to provide documentation for the policies and procedures for the provision of subsistence needs for staff and residents, whether they evacuate or shelter in place. Based on interview at the time of record review, the Administrator confirmed that no documentation was available to review for the policies and procedure for the provision of subsistence needs for staff and residents, whether they evacuate or shelter in place. This item was discussed with the Maintenance Director and the facility Administrator at the exit conference on 03/28/23 at 2:30 p.m.	E 0015	**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 Plan will be updated to include policies and procedures for the provision of subsistence needs for staff and residents, whether they evacuate or shelter in place. **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 updated to include policies and procedures for the provision of subsistence needs for staff and residents, whether they evacuate or shelter in place. **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 updated to include	04/27/2023

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			policies and procedures for the provision of subsistence needs for staff and residents, whether they evacuate or shelter in place. All staff will be educated in regard to the Emergency Preparedness Plan policies and procedures for the provision of subsistence needs for staff and residents, whether they evacuate or shelter in place. **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 policies and procedures for the provision of subsistence needs for staff and residents, whether they evacuate or shelter in place monthly times 6 months, then annually thereafter. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly.	
E 0018 SS=C Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2),			

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	§485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [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 [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures.			

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	(ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the	E 0018	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been**	04/27/2023

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	location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.73(b) (2). This deficient practice could affect all occupants. Findings include: Based on record review with the facility Administrator on 03/28/23 at 1:43 p.m., no documentation could be found ensuring the emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location. Based on interview at the time of record review, the Administrator confirmed they did not have a policy or procedure in place for tracking staff or residents during an emergency. This item was discussed with the Maintenance Director and the facility Administrator at the exit conference on 03/28/23 at 2:30 p.m.		**Affected By The Deficient Practice:** No residents were affected by this alleged deficient practice. The Emergency Preparedness Plan policies and procedures will be updated to include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. **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 policies and procedures will be updated to include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. **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 policies and procedures will be updated to include a system to track the location of on-duty staff and sheltered residents in the LTC	

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			facility's care during and after an emergency. All staff will be educated in regard to The Emergency Preparedness Plan policies and procedures to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. **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 policies and procedures to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency monthly times 6 months, then annually thereafter. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly.	
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),			

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	§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]. Based on record review and interview, the facility failed to develop 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 record review with the facility Administrator on 03/28/23 at 2:00 p.m., the facility emergency preparedness plan did not include a written communication plan. Based on an interview with the facility Administrator at the time of record review, she confirmed that a communication plan could not be provided for review as of the time of this survey. This item was discussed with the Maintenance Director and the facility Administrator at the exit conference on 03/28/23 at 2:30 p.m.	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 Plan will be updated to include a communication plan. **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 updated to include a communication plan. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:**	04/27/2023

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			The Emergency Preparedness Plan will be updated to include a communication plan. The Maintenance Director will be educated in regard to the Emergency Preparedness communication plan. **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 communication plan monthly times 6 months, then annually thereafter. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly.	
E 0032 SS=C Bldg. --	403.748(c)(3), 416.54(c)(3), 418.113(c)(3), 441.184(c)(3), 482.15(c)(3), 483.475(c)(3), 483.73(c)(3), 484.102(c)(3), 485.625(c)(3), 485.68(c)(3), 485.727(c)(3), 485.920(c)(3), 486.360(c)(3), 491.12(c)(3), 494.62(c)(3) Primary/Alternate Means for Communication §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(c) The [facility] must develop and maintain an emergency preparedness communication			

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	plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies.			
	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (3) Primary and alternate means for communicating with the following: (i) LTC facility's staff (ii) Federal, State, tribal, regional, or local emergency management agencies in accordance with 42 CFR 483.73(c) (3). This deficient practice could affect all occupants. Findings include: Based on record review with the facility Administrator on 03/28/23 at 2:02 p.m., the facility could not provide an emergency preparedness communication plan that includes primary and alternate means for communicating with the following: LTC facility's staff; Federal, State, tribal, regional, or local emergency management agencies. Based on interview at the time of record review, the facility Administrator stated they would use landlines, cell phones, and walkie-talkies, but did not have any policy regarding primary and alternate means of	E 0032	What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice: /p> **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:** /p> **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** /p> **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:**	04/27/2023

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	communication to include when and how various means would be used. This item was discussed with the Maintenance Director and the facility Administrator at the exit conference on 03/28/23 at 2:30 p.m.		**The Maintenance Director/Designee will monitor the Emergency Preparedness communication plan monthly times 6 months, then annually thereafter. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly.**	
E 0039 SS=C Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is			

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	155743	A. BUILDING -- B. WING	03/28/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility			

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	based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the			

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	emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual			

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	exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include,			

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	but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility			

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	based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is			

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	led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group			

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	discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a			

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	narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop	E 0039	**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 facility will conduct an exercise to test the facility's Emergency Preparedness Plan. **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 facility will conduct an exercise to test the facility's Emergency Preparedness Plan. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** The facility will conduct an exercise to test the facility's	04/27/2023

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	exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the facility Administrator on 03/28/23 at 2:12 p.m., the facility could not provide any of the following: an annual full-scale exercise that is community-based, an annual individual, facility-based functional exercise, or documentation of an actual natural or man-made emergency that requires activation of the emergency plan. Furthermore, the facility could not provide documentation on an additional exercise that may include, but is not limited to the following: second full-scale exercise that is community-based or an individual, facility-based functional exercise, a mock disaster drill, or a tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. Based on an interview at the time of record review, the facility Administrator acknowledged that no documentation could be located to review for any of the aforementioned drills or exercises. This item was discussed with the Maintenance Director and the facility Administrator at the exit conference on 03/28/23 at 2:30 p.m.		Emergency Preparedness Plan. The Maintenance Director will be educated in regard to the policy and procedure of conducting 2 exercises annually to test the facility's Emergency Preparedness Plan. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** The Maintenance Director/Designee will monitor the completion of exercises to test the facility's Emergency Preparedness Plan monthly times 12 months, then every 6 months thereafter. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana	K 0000	**This plan of correction is to serve as Greenhill Manor**	

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	Department of Health in accordance with 42 CFR 483.90(a). Survey date: 03/28/23 Facility Number: 000288 Provider Number: 155743 AIM Number: 100287380 At this Life Safety Code survey, Greenhill Manor Inc. 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 (000) 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 26 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 03/30/23		**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.**	
K 0281 SS=F Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8			

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	and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on observation and interview, the facility failed to ensure egress lighting was either continuously in operation or capable of automatic operation without manual intervention.at 6 of 6 exits. Section 7.8.1.2 requires illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. This deficient practice could affect all residents, staff, and visitors. Finding include: Based on observations with the Maintenance Director during a tour of the facility on 01/30/17 at 1:26 a.m., the exterior exit discharge lighting at six of the six facility exits could be controlled by a switch. Based on interview and observations at all of the exit doors, the Maintenance Director was able to turn the egress lights off with a switch located at the exit door. Based on an interview at the time of each observation, the Maintenance Director confirmed all egress lighting at each exit was powered by a switch located at the exit door. This item was discussed with the Maintenance Director and the facility Administrator at the exit conference on 03/28/23 at 2:30 p.m. 3.1-19(b)	K 0281	**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 facility will install automatic dusk-to-dawn lights at all six of the facility's exit doors and the light switch at each exit will be covered with a light switch plate. **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 facility will install automatic dusk-to-dawn lights at all six of the facility's exit doors and the light switch at each exit will be covered with a light switch plate. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** The facility will install automatic dusk-to-dawn lights at all six of	04/27/2023

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			the facility's exit doors and the light switch at each exit will be covered with a light switch plate. The Maintenance Director will be educated in regard to the regulation for Illumination of Means of Egress. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** The Maintenance Director/Designee will monitor the automatic dusk-to-dawn lights and switch covers at each of the facility's exit doors weekly times 2 months, then monthly times six months, then quarterly thereafter. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or			

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

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	automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure the corridor door to 2 of over 8 hazardous areas, such as a House Keeping/Bio-hazard room, a storage room of combustible supplies over 50 square feet in size, was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect as many as 14 residents, 3 staff, and 2 visitors. Findings include: Based on observations made during a tour of the facility on 03/28/23 at 12:38 p.m. with the Maintenance Director, the corridor door to resident rooms #28 and #29 had been converted to storage. These rooms contained assorted items	K 0321	**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 facility will install self-closing devices to resident rooms #28 and #29 that are being used for storage. **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:**	04/27/2023

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	including: recliners, wooden furniture and dressers, bags of miscellaneous clothing items, and other assorted combustible items creating a hazardous area. Both rooms also measured well over the 50 square feet. The lack of a self-closing device being installed on the corridor doors to each of these converted rooms was acknowledged by the Maintenance Director who stated that he would have one installed on each room door as soon as he could. This item was discussed with the Maintenance Director and the facility Administrator at the exit conference on 03/28/23 at 2:30 p.m. 3.1-19(b)		All residents have the potential to be affected, no other residents were affected by this alleged deficient practice. The facility will install self-closing devices to resident rooms #28 and #29 that are being used for storage. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** The facility will install self-closing devices to resident rooms #28 and #29 that are being used for storage. The Maintenance Director will be educated in regard to the regulation for Hazardous Areas-Enclosures. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** The Maintenance Director/Designee will monitor storage areas for self-closing devices monthly times 6 months, then quarterly thereafter. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly.	
K 0363 SS=E	NFPA 101 Corridor - Doors			

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Bldg. 01	Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing			

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	devices, etc. Based on observation and interview, the facility failed to ensure 1 of 34 resident room doors to the corridor would close completely and latch into the door frame. This deficient practice could affect as many as 14 residents, 3 staff, and 2 visitors. Findings include: Based on observations made during a tour of the facility on 03/28/23 at 12:48 p.m. with the Maintenance Director, the corridor door to resident room # 34 was extremely difficult to close and latch. Based on interview at the time of observations, the Maintenance Director acknowledged the aforementioned condition and stated that it must have swollen and that he would shave it down as soon as he could so that it closed and latched much easier for the resident and staff. This item was discussed with the Maintenance Director and the facility Administrator at the exit conference on 03/28/23 at 2:30 p.m. 3.1-19(b)	K 0363	**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 corridor door to resident room #34 has been fixed to close properly. **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. The corridor door to resident room #34 has been fixed to close properly. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** The corridor door to resident room #34 has been fixed to close properly. The Maintenance Director will be educated in regard to the regulation over corridor doors. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:**	04/27/2023

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			Maintenance Director/Designee will monitor proper closure of corridor doors monthly ongoing to ensure proper closure. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly.	
K 0521 SS=E Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on observation and interview, the facility failed to ensure egress corridors were not used as a portion of a return air system serving adjoining rooms for four of 64 rooms. LSC 9.2.1 requires air conditioning, heating, ventilating, ductwork, and related equipment to be installed in accordance with NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, Section 4.3.12.1.1 states egress corridors in nursing and long-term care facilities shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas unless otherwise permitted by 4.3.12.1.3.1 through 4.3.12.1.3.4. This deficient practice could affect as many as 20 residents, 4 staff and 2 visitors. Findings include: Based on observations made during a tour of the facility with the Maintenance Director on 01/30/17	K 0521	**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. Return air vents will be installed in the MDS office, the SSD office, the Housekeeping/Laundry office, and the laundry room. **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	04/27/2023

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	between 11:30 a.m. to 1:24 p.m., the following rooms were using the egress corridor as a return air system: a) The Housekeeping / Laundry office. b) The MSD office. c) The social services office. d) The Laundry room. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned room and support offices were using the egress corridor as a return air system. This item was discussed with the Maintenance Director and the facility Administrator at the exit conference on 03/28/23 at 2:30 p.m. 3.1-19(b)		were affected by this alleged deficient practice. Return air vents will be installed in the MDS office, the SSD office, the Housekeeping/Laundry office, and the laundry room. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** Return air vents will be installed in the MDS office, the SSD office, the Housekeeping/Laundry office, and the laundry room. The Maintenance Director will be educated in regard to the regulation for HVAC-Ventilation. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** Maintenance Director/Designee will monitor offices for return air ventilation monthly times 6 months, then bi-annually thereafter. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly.	
K 0522 SS=E Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central			

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	heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms was provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for all staff in the laundry room. Findings include: Based on observations made during a tour of the facility on 03/28/23 at 12:15 p.m. with the Maintenance Director, the laundry room had two fuel fired dryers. Based on interview, when asked where the outside air source for the dryers was, none could be located. This was acknowledged by the Maintenance Director at the time of observation who stated that he would have to add one as soon as he could. This item was discussed with the Maintenance Director and the facility Administrator at the exit conference on 03/28/23 at 2:30 p.m. 3.1-19(b)	K 0522	**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 fresh air intake will be installed in the laundry room. **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 fresh air intake will be installed in the laundry room. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** A fresh air intake will be installed	04/27/2023

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			in the laundry room. The Maintenance Director will be educated in regard to the requirements for fresh air intakes. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** Maintenance Director/Designee will monitor fresh air intakes monthly times 6 months, then quarterly times 2 quarters, then annually ongoing. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits			

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	smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview, the facility failed to ensure 1 of 1 area where smoking was permitted for staff and residents was maintained in accordance with 19.7.4. LSC 19.7.4 requires ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. Metal containers with a self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas were smoking is permitted. This deficient practice could affect staff only. Findings include: Based on observations with the Maintenance Director on 01/30/17 at 11:28 a.m., there were approximately 40 to 50 cigarette butts on the ground outside the kitchen entrance near the generator. Based on interview at the time of observation, the Maintenance Director acknowledged the 40 to 50 cigarette butts on the ground at the employee entrance and stated that he had placed an approved container in the area but could not make every smoker use it. This item was discussed with the Maintenance	K 0741	**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. Cigarette butts have been cleaned up at the employee entrance near the kitchen. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents residing in the facility have the potential to be affected, no other residents were affected by this alleged deficient practice. Cigarette butts have been cleaned up at the employee entrance near the kitchen. **What Measures Will Be Put Into**	04/27/2023

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	Director and the facility Administrator at the exit conference on 03/28/23 at 2:30 p.m. 3.1-19(b)		**Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** Cigarette butts have been cleaned up at the employee entrance near the kitchen. All staff including the Maintenance Director will be educated in regard to the requirement of proper cigarette disposal. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** Maintenance Director/Designee will monitor designated smoking areas daily on scheduled workdays times 30 days, then weekly ongoing. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum of 6 months and the plan adjusted accordingly.	
K 0751 SS=E Bldg. 01	NFPA 101 Draperies, Curtains, and Loosely Hanging Fabr Draperies, Curtains, and Loosely Hanging Fabrics Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient			

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	sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1 Based on observation and interview, the facility failed to provide a flame spread rating document that showed curtains hanging in the Physical Therapy area were inherently flame retardant or complied with NFPA 701 Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. NFPA 101 Life Safety Code, 2012 Edition at 19.7.5.1 states: Draperies, curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies shall be in accordance with the provisions of 10.3.1 (see 19.3.5.11), and the following also shall apply: (4) Such draperies and curtains shall not include draperies and curtains in other rooms or areas where the draperies and curtains comply with all of the following: (a) Individual drapery or curtain panel area does not exceed 48 square feet. This deficient practice could affect as many as 4 residents, 4 staff, and 1 visitor in the facility. Findings include: Based on observations made during a tour of the facility on 03/28/23 at 11:54 a.m. with the Maintenance Director, there were two sets of curtains hanging in the Therapy area. These curtains extended from the ceiling to the floor and were approximately 12 feet wide by 10 feet high or 120 square feet in size. Based on an interview at the time of the observation, when asked if the curtains were inherently flame retardant or met NFPA 701 standards for curtains in a healthcare facility, the Maintenance Director answered no,	K 0751	**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 two sets of curtains in the Therapy area have been sprayed with a flame-retardant chemical. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents residing in the facility have the potential to be affected, no other residents were affected by this alleged deficient practice. The two sets of curtains in the Therapy area have been sprayed with a flame-retardant chemical. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** The two sets of curtains in the Therapy area have been sprayed with a flame-retardant chemical. The Maintenance Director will	04/27/2023

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	they were not. The Maintenance Director then added that he would have them sprayed with a flameproofing spray or remove and replace them with curtains that met the code requirements. This item was discussed with the Maintenance Director and the facility Administrator at the exit conference on 03/28/23 at 2:30 p.m. 3.1-19(b)		spray the curtains bi-annually and appropriate documentation will be maintained. The Maintenance Director will be educated in regard to the regulation for Draperies, Curtains, and Loosely Hanging Fabrics. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** Maintenance Director/Designee will monitor the curtains located in the Therapy room for flame-retardant spray and appropriate documentation of such quarterly times 2 quarters, then bi-annually thereafter. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum of 6 months and the plan adjusted accordingly.	
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on record review, observation, and interview; the facility failure to ensure 1 of 1 portable space heaters in use was compliant with	K 0781	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been**	04/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155743	A. BUILDING 01 B. WING	03/28/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the facility's space heather policy. This deficient practice could affect as many as 10 residents, 4 staff and 2 visitors. Findings include: Based on observations made during a tour of the facility on 03/28/23 at 12:01 p.m. with the Maintenance Director, a portable space heater was under the desk in the Business office. Manufacturer's documentation affixed to the portable space heater did not state the maximum temperature achieved by the unit. Based on interview at the time of observation, the Maintenance Director stated portable space heaters are allowed to be used in the facility but acknowledged that he had no documentation to show that this portable space heater met the requirements set forth in the facility's space heater policy. Based on review of facility policy entitled "Portable Electrical Heaters Policy" documentation, it is clearly stated that the heating element of said space heaters can not exceed 212 degrees Fahrenheit (100 degrees Celsius) This item was discussed with the Maintenance Director and the facility Administrator at the exit conference on 03/28/23 at 2:30 p.m. 3.1-19(b)		**Affected By The Deficient Practice:** No residents were affected by this alleged deficient practice. The portable space heater was removed from the Business Office in 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 residing in the facility have the potential to be affected, no other residents were affected by this alleged deficient practice. The portable space heater was removed from the Business Office in 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 portable space heater was removed from the Business Office in the facility. All staff including the Maintenance Director will be educated in regard to the space heater policy and procedure. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** Maintenance Director/Designee will monitor all areas of the facility	

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			for space heaters monthly times 6 months, then quarterly ongoing. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum of 6 months and the plan adjusted accordingly.	
K 0916 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator was provided with an alarm annunciator in a location readily observed by operating personnel at a regular workstation such as a nurses' stations. NFPA 99, 2012 Edition, Health Care Facilities Code, at 6.4.1.1.17 requires a remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular workstation. The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows: (1) Individual visual signals shall indicate: a. When the emergency or auxiliary power source is operating to supply power to load.	K 0916	**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 generator will be connected to the facility remote annunciator. **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:**	04/27/2023

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	b. When the battery charger is malfunctioning. (2) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate: a. Low lubricating oil pressure. b. Low water temperature. c. Excessive water temperature. d. Low fuel when the main fuel storage tank contains less than a 4-hour operating supply. e. Overcrank (failed to start). f. Overspeed. Where a regular workstation will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 6.4.1.1.17(1) and (2) occur but need not display these conditions individually. This deficient practice could affect all patients, as well as staff and visitors in the facility. Findings include: Based on interview during record review on 03/28/23 at 10:12 a.m., the EOC Maintenance Director said the facility has a replacement emergency generator while management determined what to do with the facility generator that had stopped working. Based on observations made during a tour of the facility, the annunciator panel at the main nurse's station was still connected to the broken generator, therefore the current replacement generator did not have a working continuously monitored annunciator attached to it. Based on an interview at the time of the observation, the Maintenance Director agreed that the current emergency generator was not attached to a continuously monitored annunciator panel and that he would advise his management of the need to get it compliant as soon as		All residents have the potential to be affected, no other residents were affected by this alleged deficient practice. The generator will be connected to the facility remote annunciator. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** The generator will be connected to the facility remote annunciator. The Maintenance Director will be educated in regard to the requirements for the generator annunciator panel. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** Maintenance Director/Designee will monitor the generator annunciator panel monthly ongoing. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly.	

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	possible. This item was discussed with the Maintenance Director and the facility Administrator at the exit conference on 03/28/23 at 2:30 p.m. 3.1-19(b)			