PRINTED: 04/19/2023

	T OF HEALTH AND HU! R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
STATEME	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155743	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/28/2023	
	PROVIDER OR SUPPLIEF		•	501 N	ADDRESS, CITY, STATE, ZIP COD LINCOLN AVE ER, IN 47944		
(X4) ID PREFIX TAG E 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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)	ATE	(X5) COMPLETION DATE
Bldg	conducted by the In accordance with 42  Survey Date: 03/28  Facility Number: 0  Provider Number: 100  At this Emergency Manor was found in Emergency Prepare Medicare and Mediand Suppliers, 42 C  The facility has 64 the survey, the cens	00288 155743 287380  Preparedness survey, Greenhill in substantial compliance with edness Requirements for caid Participating Providers FR 483.73  certified beds. At the time of	E 0	000	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	(1), 482.15(b)(1), 485.625(b)(1) Subsistence Need §403.748(b)(1), §4 §441.184(b)(1), §4 §483.73(b)(1), §4 [(b) Policies and p must develop and preparedness poli	8.113(b)(6)(iii), 441.184(b) 483.475(b)(1), 483.73(b)(1), ds for Staff and Patients 418.113(b)(6)(iii), 460.84(b)(1), §482.15(b)(1), 83.475(b)(1), §485.625(b)(1) procedures. [Facilities] implement emergency icies and procedures, based or plan set forth in paragraph					

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

(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

(X6) DATE

TITLE

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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	OF CORRECTION	IDENTIFICATION NUMBER  155743	ľ	UILDING	nstruction 	COMPL 03/28/	ETED
	PROVIDER OR SUPPLIER	£		501 N L	ADDRESS, CITY, STATE, ZIP COD INCOLN AVE IR, IN 47944		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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)	ATE	(X5) COMPLETION DATE
	[annually for LTC	updated every 2 years facilities]. At a minimum, rocedures must address					
	staff and patients shelter in place, in to the following: (i) Food, water, m supplies (ii) Alternate source the following: (A) Temperatures and safety and for storage of provision (B) Emergency light (C) Fire detection, systems. (D) Sewage and voor *[For Inpatient Ho Policies and proceed (6) The following a for hospice-operationly. The policies address the followings.	hting. , extinguishing, and alarm  vaste disposal.  spice at §418.113(b)(6)(iii):] edures. are additional requirements ted inpatient care facilities and procedures must ving:					
	hospice employee they evacuate or s are not limited to t (A) Food, water, n supplies. (B) Alternate sour the following: (1) Temperatures	nedical, and pharmaceutical ces of energy to maintain to protect patient health					
	storage of provision (2) Emergency lig						

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155743	(X2) MULT A. BUILI B. WING	DING	<u></u>		x3) date survey completed 03/28/2023	
GREENH	ROVIDER OR SUPPLIER		5	601 N LI	DDRESS, CITY, STATE, ZIP COD INCOLN AVE R, IN 47944			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PR	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	systems.  (C) Sewage and we Based on record reversal failed to ensure emerged and procedures included provision of subsists residents, whether the place, include, but a (i) Food, water, measupplies. (ii) Altern maintain - (A) Temple health and safety and storage of provision Fire detection, exting and (D) Sewage and with 42 CFR 483.73 could affect all occurrence with the provide documentation and the forestaff and resident shelter in place. Based on record reversal for the procedures and procedures and procedures and procedures and procedures for the procedures and procedures for the procedures and procedures and procedures and procedures and procedures for the procedures and procedures and procedures and procedures for the procedures and procedures for the procedures and procedures and procedures and procedures for the procedures and procedures for the procedures and procedures and procedures for the procedures	vaste disposal. view and interview, the facility ergency preparedness policies ude at a minimum, (1) The ence needs for staff and they evacuate or shelter in are not limited to the following: dical, and pharmaceutical ate sources of energy to peratures to protect resident d for the safe and sanitary as; (B) Emergency lighting; (C) aguishing, and alarm systems; d waste disposal in accordance (B(b)(1). This deficient practice apants.  The Maintenance Director on and, the facility was unable to dispose of subsistence needs atts, whether they evacuate or seed on interview at the time of administrator confirmed that was available to review for the cure for the provision of staff and residents, whether elter in place.  Seed with the Maintenance willity Administrator at the exit	E 001:		What Corrective Action(s) Williams Accomplished For Those Residents Found To Have Be Affected By The Deficient Practice:  No residents were affected by alleged deficient practice. The Emergency Preparedness Pla will be updated to include policiand procedures for the provisis subsistence needs for staff an residents, whether they evacu or shelter in place.  How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified Ar What Corrective Action(s) Will Be Taken:  All residents have the potential be affected, no other residents were found to be affected by the alleged deficient practice. The Emergency Preparedness Pla will be updated to include policiand procedures for the provisis subsistence needs for staff an residents, whether they evacu or shelter in place.  What Measures Will Be Put In Place and What Systemic	this n cies on of d ate  I I I I I I I I I I I I I I I I I I	04/27/2023	
	conference on 03/28	<i>9.23</i> at 2.30 p.111.			Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur: The Emergency Preparedness Plan will be updated to include			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
ANDTLAIN	OI CORRECTION	155743	B. WI		<del></del>	03/28/	
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				INCOLN AVE		
GREENH	IILL MANOR		_		ER, IN 47944		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	policies and procedures for the		DATE
					provision of subsistence need		
					staff and residents, whether th		
					evacuate or shelter in place.	ĺ	
					All staff will be educated in reg	gard	
					to the Emergency Preparedne		
					Plan policies and procedures		
					the provision of subsistence n		
					for staff and residents, whether		
					they evacuate or shelter in pla	ice.	
					How The Corrective Action(s	<sub>s)</sub>	
					Will Be Monitored To Ensure	· .	
					The Deficient Practice Will N	ot	
					Recur:		
					The Maintenance		
					Director/Designee will monitor		
					Emergency Preparedness Pla		
					policies and procedures for the		
					provision of subsistence need staff and residents, whether the		
					evacuate or shelter in place	ЕУ	
					monthly times 6 months, then		
					annually thereafter. Any negat		
					findings will be corrected		
					immediately and forwarded to	the	
					Administrator. A report of prog	ress	
					will be forwarded to the QAPI		
					committee monthly for a minin		
					of 6 months and the plan adju	sted	
					accordingly.		
E 0018	403.748(b)(2), 416	6.54(b)(1), 418.113(b)(6)(ii)					
SS=C	and (v), 441.184(b						
Bldg	` '	3.73(b)(2), 485.625(b)(2),					
	( / ( / ·	6.360(b)(1), 494.62(b)(1)					
		acking of Staff and Patients					
	- ,,,,	116.54(b)(1), §418.113(b)(6)					
	. , . , -	84(b)(2), §460.84(b)(2), 33.73(b)(2), §483.475(b)(2).					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155743	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION  G <u></u>	COMI	E SURVEY PLETED 8/2023
	PROVIDER OR SUPPLIEF	2	501	EET ADDRESS, CITY, STATE, ZIF N LINCOLN AVE WLER, IN 47944	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO TH	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	§485.625(b)(2), §4(1), §494.62(b)(1)	485.920(b)(1), §486.360(b)				
	must develop and preparedness polion the emergency (a) of this section, paragraph (a)(1) communication pl section. The polic reviewed and upd [annually for LTC]	implement emergency dicies and procedures, based or plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this dies and procedures must be atted at least every 2 years facilities]. At a minimum, rocedures must address				
	on-duty staff and a [facility's] care dur on-duty staff and a relocated during the must document the	em to track the location of sheltered patients in the ring an emergency. If sheltered patients are the emergency, the [facility] the specific name and eiving facility or other				
	§483.73(b), ICF/II §460.84(b):] Polic system to track th and sheltered resi ICF/IID or PACE] emergency. If on- residents are relo- emergency, the [F PACE] must docu	I41.184(b), LTC at Ds at §483.475(b), PACE at ies and procedures. (2) A e location of on-duty staff idents in the [PRTF's, LTC, care during and after an -duty staff and sheltered cated during the PRTF's, LTC, ICF/IID or ment the specific name e receiving facility or other				
	*[For Inpatient Ho Policies and proce	spice at §418.113(b)(6):] edures.				

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	N OF CORRECTION	IDENTIFICATION NUMBER  155743	A. BUILDING B. WING	onstruction 	COMPLETED 03/28/2023
NAME OF	PROVIDER OR SUPPLIE	{		ADDRESS, CITY, STATE, ZIP COD LINCOLN AVE	
GREEN	HILL MANOR			ER, IN 47944	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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)	(X5) COMPLETION DATE
	includes consider needs of evacuee transportation; ide location(s) and pr of communication assistance.  (v) A system to traemployees' on-duthe hospice's care the on-duty emploare relocated durithospice must docation of the location.	on from the hospice, which ation of care and treatment es; staff responsibilities; entification of evacuation imary and alternate means with external sources of eack the location of hospice ety and sheltered patients in eaduring an emergency. If eyees or sheltered patients ing the emergency, the ument the specific name ereceiving facility or other			
	procedures. (2) S CMHC, which incl and treatment nee responsibilities; tr of evacuation loca	afe evacuation from the ludes consideration of care eds of evacuees; staff ansportation; identification ation(s); and primary and of communication with			
	procedures. (2) A documentation the actual donor infor confidentiality of p	ootential and actual donor secures and maintains the			
	procedures. (2) S dialysis facility, wh responsibilities, and Based on record re- failed to ensure em	194.62(b):] Policies and afe evacuation from the hich includes staff and needs of the patients. View and interview, the facility ergency preparedness policies lude a system to track the	E 0018	What Corrective Action(s) W Be Accomplished For Those Residents Found To Have Be	

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155743	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/28/2023
	PROVIDER OR SUPPLIER		501 N	ADDRESS, CITY, STATE, ZIP COD LINCOLN AVE ER, IN 47944	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
IAU	location of on-duty in the LTC facility's emergency. If on-duty residents are relocated LTC facility must deficient of the recein accordance with deficient practice construction. Findings include:  Based on record revaluation coul emergency prepared include a system to staff and sheltered recare during and after staff and sheltered recare during and after staff and sheltered recare during and after the emergency, the the specific name and facility or other locatime of record reviet they did not have a for tracking staff or emergency.  This item was discutting the construction of the construction of the construction of the construction.	staff and sheltered residents are care during and after an anty staff and sheltered are during the emergency, the ocument the specific name and ving facility or other location 42 CFR 483.73(b) (2). This could affect all occupants.  The with the facility 3/28/23 at 1:43 p.m., no do be found ensuring the disest policies and procedures track the location of on-duty residents in the LTC facility's are an emergency. If on-duty residents are relocated during LTC facility must document and location of the receiving attion. Based on interview at the w, the Administrator confirmed policy or procedure in place residents during an assed with the Maintenance attifuty Administrator at the exit	IAG	Affected By The Deficient Practice: No residents were affected be alleged deficient practice. The Emergency Preparedness Ple policies and procedures will be updated to include a system track the location of on-duty seand sheltered residents in the facility's care during and after emergency.  How Other Residents Having The Potential To Be Affecte By The Same Deficient Practice Will Be Identified A What Corrective Action(s) West Taken: All residents have the potential be affected, no other resident were found to be affected by alleged deficient practice. The Emergency Preparedness Ple policies and procedures will be updated to include a system track the location of on-duty seand sheltered residents in the facility's care during and after emergency.  What Measures Will Be Put Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur: The Emergency Preparedness be updated to include a system track the location of on-duty seand sheltered residents in the Emergency Preparedness be updated to include a system track the location of on-duty seand sheltered residents in the Emergency Preparedness be updated to include a system track the location of on-duty seand sheltered residents in the search sheltered residents	y this e an be to staff e LTC r an  g d  vill ial to ts this e an be to staff e LTC r an  Into

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155743	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/28/2023
	PROVIDER OR SUPPLIER		501 N	ADDRESS, CITY, STATE, ZIP COD LINCOLN AVE ER, IN 47944	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				facility's care during and after emergency. All staff will be educated in regard to The Emergency Preparedness PI policies and procedures to trathe location of on-duty staff a sheltered residents in the LTG facility's care during and after emergency.  How The Corrective Action(Will Be Monitored To Ensur The Deficient Practice Will Necur: The Maintenance Director/Designee will monitot Emergency Preparedness PI policies and procedures to trathe location of on-duty staff a sheltered residents in the LTG facility's care during and after emergency monthly times 6 months, then annually thereat Any negative findings will be corrected immediately and forwarded to the Administrator report of progress will be forwarded to months a the plan adjusted accordingly	an ack nd C r an s) e Not or the an ack nd C r an arck nd C r an arck nd C r an arck nd C r an arched and ack nd C r an arched and ack nd c r an arched and arck nd c r an arched and arched and arched and arched and arched and arched and arched arch
E 0029 SS=C Bldg	484.102(c), 485.63 485.727(c), 485.93 491.12(c), 494.62 Development of C §403.748(c), §416 §441.184(c), §460	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c),			

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	OF CORRECTION	IDENTIFICATION NUMBER  155743		JILDING	onstruction 	COMPLETED 03/28/2023	
	PROVIDER OR SUPPLIEF	R		501 N L	ADDRESS, CITY, STATE, ZIP COD LINCOLN AVE ER, IN 47944		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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
TAG	REGULATORY OF §485.68(c), §485. §485.68(c), §485. §485.920(c), §486 §494.62(c).  (c) The [facility] m an emergency preplan that complies local laws and must least every 2 years. Based on record revision of the second part communication plants tate, and local laws 483.73(c). This definition occupants.  Findings include:  Based on record revision of the second part of the second part occupants.  Findings include:  Based on record revision of the second part of the se	R LSC IDENTIFYING INFORMATION 625(c), §485.727(c), 6.360(c), §491.12(c),  ust develop and maintain eparedness communication is with Federal, State and ears [annually for LTC view and interview, the facility is emergency preparedness in that complies with Federal, is in accordance with 42 CFR icient practice could affect all view with the facility dness plan did not include a tion plan. Based on an facility Administrator at the ew, she confirmed that a in could not be provided for the of this survey.	E0			ill this in this in this in this	DATE  04/27/2023
					communication plan.  What Measures Will Be Put In Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:	nto	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155743	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	E SURVEY PLETED 3/2023
	PROVIDER OR SUPPLIEF		501 N	ADDRESS, CITY, STATE, ZIP LINCOLN AVE ER, IN 47944	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	DRRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
				The Emergency Prep Plan will be updated to communication plan. The Maintenance Directly educated in regard to Emergency Prepared communication plan.	to include a ector will be the ness	
				How The Corrective Will Be Monitored To The Deficient Practic Recur: The Maintenance Director/Designee wil Emergency Prepared communication plan r times 6 months, then thereafter. Any negati will be corrected imme forwarded to the Adm report of progress will to the QAPI committe for a minimum of 6 me the plan adjusted acc	I monitor the ness monthly annually ive findings ediately and hinistrator. A I be forwarded be monthly onths and	
E 0032 SS=C Bldg	441.184(c)(3), 483.73(c)(3), 484.485.68(c)(3), 485.486.360(c)(3), 49.491.184(c)(3), \$4.491.184(c)(3),					

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	NT OF DEFICIENCIES	IDENTIFICATION NUMBER  155743		BUILDING WING		COMPLETED 03/28/2023	
	PROVIDER OR SUPPLIEF HILL MANOR	R		501 N LI	DDRESS, CITY, STATE, ZIP COD INCOLN AVE R, IN 47944		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	local laws and mu at least every 2 ye facilities]. The co include all of the f (3) Primary and a communicating w (i) [Facility] staff. (ii) Federal, State emergency manageries.  *[For ICF/IIDs at § and alternate meat the ICF/IID's staff regional, and locat agencies.  Based on record refailed to ensure the communication plate alternate means for following: (i) LTC tribal, regional, or lagencies in accordate This deficient pract.  Based on record reverse Administrator on Occuld not provide a communication plate alternate means for following: LTC fact regional, or local entry agencies. Based on review, the facility would use landlines walkie-talkies, but walkie-talkies, but with the communication plate agencies. Based on review, the facility would use landlines walkie-talkies, but walkie-talkies, but with the communication plate agencies.	Iternate means for ith the following:  Itribal, regional, and local gement agencies.  [3483.475(c):] (3) Primary and for communicating with a Federal, State, tribal, I emergency management view and interview, the facility emergency preparedness in includes (3) Primary and communicating with the facility's staff (ii) Federal, State, ocal emergency management ince with 42 CFR 483.73(c) (3). ice could affect all occupants.  It with the facility in emergency preparedness in that includes primary and communicating with the illity's staff; Federal, State, tribal, mergency management interview at the time of record Administrator stated they	E 003	2	What Corrective Action(s) Will Accomplished For Those Residents Found To Have Bee Affected By The Deficient Practice: /p> How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified An What Corrective Action(s) Will Be Taken: /p> What Measures Will Be Put In 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:	en I Ind iII Into	04/27/2023

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	OF CORRECTION	IDENTIFICATION NUMBER  155743	A. BUILDING B. WING	JNSTRUCTION	COM	PLETED 28/2023
	PROVIDER OR SUPPLIER		501 N I	ADDRESS, CITY, STATE, 2 LINCOLN AVE ER, IN 47944	ZIP COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE ACT: CROSS-REFERENCED TO DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	means would be use	ssed with the Maintenance ility Administrator at the exit		The Maintenance Director/Designee the Emergency Pr communication pl times 6 months, th thereafter. Any ne findings will be co immediately and f the Administrator. progress will be fo the QAPI committe for a minimum of the plan adjusted	eparedness an monthly nen annually gative orrected orwarded to A report of orwarded to ee monthly 6 months and	
E 0039 SS=C Bldg	441.184(d)(2), 482 483.73(d)(2), 484. 485.68(d)(2), 485. 486.360(d)(2), 491 EP Testing Requir §416.54(d)(2), §41 §460.84(d)(2), §48 §483.475(d)(2), §4 (2), §491.12(d)(2), *[For ASCs at §41 OPO, "Organization CMHCs at §485.92 §491.12, and ESR (2) Testing. The [faction of the content of the con	8.113(d)(2), §441.184(d)(2), 82.15(d)(2), §483.73(d)(2), 84.102(d)(2), §485.68(d)(2), 85.727(d)(2), §485.920(d) §494.62(d)(2). 6.54, CORFs at §485.68, 908" under §485.727, 20, RHCs/FQHCs at D Facilities at §494.62]: acility] must conduct the emergency plan lity] must do all of the				

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Event ID:

YKNZ21

Facility ID: 000288

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	MENT OF DEFICIENCIES  AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155743	l í	JILDING	NSTRUCTION	(X3) DATE COMPI 03/28	LETED		
	OF PROVIDER OR SUPPLIES  NHILL MANOR	₹	STREET ADDRESS, CITY, STATE, ZIP COD 501 N LINCOLN AVE FOWLER, IN 47944						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE		
	functional exercise  (B) If the [factor natural or man-mactivation of the exercise is exempt from exercise actual event.  (ii) Conduct an actual event.  (ii) Conduct an actual event every 2 years, oper functional exercise functional exercise functional exercise functional exercise functional exercise (B) A mock disast (C) A tabletop exelled by a facilitation discussion using clinically-relevant set of problem star messages, or present to challenge an exercises, and enthe [facility's] emethics for the patient's home conduct exercises plan at least annual the following:  (i) Participate in a community based (A) When a community based (A	ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan. acility's] response to and intation of all drills, tabletop inergency events, and revise ergency plan, as needed.							

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Event ID:

YKNZ21 Facility ID: 000288

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PRINTED: 04/19/2023 FORM APPROVED OMB NO. 0938-039

	ENT OF DEFICIENCIES  N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155743	ľ	UILDING	NSTRUCTION	COM	PLETED 28/2023		
	F PROVIDER OR SUPPLIEI	R	STREET ADDRESS, CITY, STATE, ZIP COD 501 N LINCOLN AVE FOWLER, IN 47944						
(X4) ID PREFIX	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION		
TAG	based functional of (B) If the hospice man-made emerge of the emergency exempt from engascale community-facility-based functional exercis of this section is conclude, but is not (A) A second full-community-based functional exercis (B) A mock disast (C) A tabletop extended by a facilitator discussion using a clinically-relevant set of problem stamessages, or preto challenge an election of the care directly. The exercises to test to per year. The hospice man-made emergency exempt from engafull-scale community for the emergency exempt from engafull-scale community.	exercise every 2 years; or experiences a natural or gency that requires activation plan, the hospital is aging in its next required full based exercise or individual ctional exercise following the gency event.  dditional exercise every 2 are year the full-scale or e under paragraph (d)(2)(i) conducted, that may ilmited to the following: escale exercise that is a or a facility based e; or ster drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan.  spices that provide inpatient e hospice must conduct the emergency plan twice spice must do the following: an annual full-scale exercise		TAG	DISTRIBUTE IT		DATE		

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Event ID:

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PRINTED: 04/19/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155743	A. BUILDING B. WING		COMI	PLETED 8/2023
	PROVIDER OR SUPPLIER		501 N I	ADDRESS, CITY, STATE, ZIP C LINCOLN AVE ER, IN 47944	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	that may include, I following:  (A) A second full-community-based functional exercises (B) A mock disast (C) A tabletop exe facilitator that inclusing a narrated, cemergency scenar statements, direct questions designe emergency plan.  (iii) Analyze the himaintain document exercises, and emithe hospice's eme  *[For PRFTs at §4 §482.15(d), CAHs (2) Testing. The [Ficonduct exercises plan twice per year CAH] must do the (i) Participate in a that is community-(A) When a community-(A) When a community-(A) When a community-(B) If the [PRTF, Hean actual natural content of the plan, the [facility] is its next required fuor individual, facility or individual, facility is sext required fuor individual, facility is next required fuor individual	e; or fer drill; or fer drill; or fercise or workshop led by a findes a group discussion clinically-relevant finder, and a set of problem finded messages, or prepared d to challenge an finder of all drills, tabletop f				
	(ii) Conduct a	an [additional] annual				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155743			l í	UILDING	INSTRUCTION	COMPL 03/28/	ETED
NAME OF	PROVIDER OR SUPPLIEF			501 N L	ADDRESS, CITY, STATE, ZIP COD INCOLN AVE		
GREEN	HILL MANOR			FOWLE	R, IN 47944		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
IAG	exercise or and the limited to the follow (A) A second full-community-based facility-based function (B) A monomorphism (C) A tabletop is led by a facilitate discussion, using clinically-relevant set of problem star messages, or preparent to challenge an ereceive (iii) Analyze the and maintain docutabletop exercises and revise the [factor of the exercises plan at least annuorganization must (i) Participate in a that is community (A) When a commaccessible, conducted facility-based function of the exercise or man-made emergent from entitle functional exercises functional exercises functional exercises or an exercise functional exercises or an exercise functional exercises or an exercise functional exercises functional exercises or an exercise functional exercises functional exercises or an exercise functional exer	at may include, but is not wing: scale exercise that is or individual, a stional exercise; or ock disaster drill; or ocxercise or workshop that or and includes a group a narrated, emergency scenario, and a tements, directed orared questions designed mergency plan. The [facility's] response to umentation of all drills, and emergency events cility's] emergency plan, as  60.84(d):] ACE organization must at to test the emergency ally. The PACE do the following: an annual full-scale exercise ebased; or annual individual, stional exercise; or experiences an actual natural ergency that requires mergency plan, the PACE gaging in its next required and or individual, stional exercise following the		IAU			DATE

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	MENT OF DEFICIENCIES  AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155743		UILDING	NSTRUCTION	COM	re survey ipleted 28/2023		
	OF PROVIDER OR SUPPLIES  ENHILL MANOR	R	STREET ADDRESS, CITY, STATE, ZIP COD 501 N LINCOLN AVE FOWLER, IN 47944						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OUT D BE	(X5) COMPLETION DATE		
140	but is not limited to (A) A second full-community-based based functional (B) A mock disas (C) A tabletop excled by a facilitator discussion, using clinically-relevant set of problem star messages, or preto challenge an etii) Analyze the Famintain docume exercises, and enthe PACE's emer [For LTC Facilities (2) The [LTC facilitotest the emergency procedure of the emergency procedure of the participate in a start is community (A) When a community (A) When a community (B) If the [LTC facility-based function of the participate in a start is community (B) If the second facility-based function of the participate in a start is community (C) (B) If the second facility-based function of the participate in a start is community (C) (B) If the second full-second following the onset (ii) Conduct an authat may include, following: (A) A second full-	to the following:scale exercise that is d or individual, a facility exercise; or ster drill; or tercise or workshop that is r and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan. PACE's response to and ntation of all drills, tabletop nergency events and revise gency plan, as needed. es at §483.73(d):] lity] must conduct exercises ency plan at least twice per nannounced staff drills using rocedures. The [LTC facility, the following: an annual full-scale exercise r-based; or nunity-based exercise is not uct an annual individual,							

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER			UILDING ING	INSTRUCTION	COMPI 03/28	ETED
	DF PROVIDER OR SUPPLIEI NHILL MANOR	· ·		501 N L	ADDRESS, CITY, STATE, ZIP COD INCOLN AVE ER, IN 47944		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	led by a facilitator discussion, using clinically-relevant set of problem star messages, or preto challenge an el (iii) Analyze the [I response to and rall drills, tabletop events, and revise emergency plan, set [For ICF/IIDs at § (2) Testing. The Idexercises to test to twice per year. The following:  (i) Participate in a that is community (A) When a community (A) When a community (B) If the ICF/IID enatural or man-mactivation of the elis exempt from erfull-scale community-based functions of the emer (ii) Conduct an adthat may include, following:  (A) A second full-community-based facility-based functions and facility-based functions are facility-based functions.	ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. LTC facility] facility's naintain documentation of exercises, and emergency e the [LTC facility] facility's as needed.  \$483.475(d)]: CF/IID must conduct the emergency plan at least the ICF/IID must do the In annual full-scale exercise abased; or funity-based exercise is not fuct an annual individual, estional exercise; or. experiences an actual adde emergency plan, the ICF/IID fugaging in its next requires mergency plan, the ICF/IID fugaging in its next required aity-based or individual, estional exercise following the gency event. ditional annual exercise but is not limited to the scale exercise that is or an individual, estional exercise; or					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155743			r í	UILDING	INSTRUCTION		LETED 8/2023
	DF PROVIDER OR SUPPLIEI NHILL MANOR	₹		501 N L	ADDRESS, CITY, STATE, ZIP COD INCOLN AVE ER, IN 47944		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	discussion, using clinically-relevant set of problem star messages, or preto challenge an el (iii) Analyze the IC maintain documel exercises, and en the ICF/IID's eme *[For HHAs at §48 (d)(2) Testing. The exercises to test the least annually. The following: (i) Participate in a community-based (A) When a community-based (A) When a community-based (B) If the HH natural or man-matural or man-mat	emergency scenario, and a stements, directed pared questions designed mergency plan.  CF/IID's response to and nation of all drills, tabletop nergency events, and revise regency plan, as needed.  34.102]  e HHA must conduct he emergency plan at e HHA must do the  full-scale exercise that is l; or community-based exercise conduct an annual based functional exercise.  A experiences an actual ade emergency plan, the HHA is aging in its next required nity-based or individual, ctional exercise following the gency event.  Iditional exercise every 2 he year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: full-scale exercise that is					

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PRINTED: 04/19/2023 FORM APPROVED OMB NO. 0938-039

	AN OF CORRECTION	IDENTIFICATION NUMBER  155743	r í	UILDING	nstruction 	COMPL 03/28/	ETED
	DF PROVIDER OR SUPPLIEI NHILL MANOR	· ·		501 N L	ADDRESS, CITY, STATE, ZIP COD INCOLN AVE IR, IN 47944		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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)	ATE	(X5) COMPLETION DATE
	set of problem star messages, or preto challenge an ei (iii) Analyze the Hamaintain documel exercises, and en the HHA's emergen *[For OPOs at §4 (d)(2) Testing. The exercises to test to OPO must do the (i) Conduct a papor or workshop at least exercise is led by group discussion, relevant emergen problem statemer prepared question emergency plan. actual natural or requires activation OPO is exempt for required testing e of the emergency (ii) Analyze the Omaintain documel exercises, and en the [RNHCl's and needed.  *[RNCHIs at §40 (d)(2) Testing. The exercises to test to RNHCl must do the conduct a paparat least annually.	emergency scenario, and a stements, directed pared questions designed mergency plan.  HA's response to and natation of all drills, tabletop mergency events, and revise ency plan, as needed.  36.360]  9 OPO must conduct the emergency plan. The following:  9 er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically by scenario, and a set of ats, directed messages, or as designed to challenge and if the OPO experiences and man-made emergency that an of the emergency plan, the box engaging in its next exercise following the onset event.  PO's response to and station of all tabletop mergency events, and revise OPO's] emergency plan, as					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	ETED
		155743	B. W	ING		03/28/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	8			INCOLN AVE		
GREENH	HILL MANOR				ER, IN 47944		
(X4) ID	CHMMADV	STATEMENT OF DEFICIENCIE		ID	1		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
ino		r-relevant emergency	+	1710			DATE
	_	et of problem statements,					
		s, or prepared questions					
		enge an emergency plan.					
	_	NHCI's response to and					
		ntation of all tabletop					
	exercises, and em	nergency events, and revise					
	the RNHCI's emer	rgency plan, as needed.					
	Based on record rev	view and interview, the facility	E 0	039	What Corrective Action(s) W	/ill	04/27/2023
		ercises to test the emergency			Be Accomplished For Those	)	
	plan at least twice p				Residents Found To Have B	een	
		drills using the emergency			Affected By The Deficient		
	_	C facility must do the			Practice:		
	following:				No residents were affected by		
		annual full-scale exercise that			alleged deficient practice. The		
	is community-based				facility will conduct an exercis	e to	
		ity-based exercise is not			test the facility's Emergency		
		an annual individual,			Preparedness Plan.		
	facility-based funct	y experiences an actual natural			Have Other Besidents Having		
		gency that requires activation			How Other Residents Having The Potential To Be Affected	-	
		lan, the LTC facility is exempt			By The Same Deficient	ı	
		ext required full-scale			Practice Will Be Identified A	nd	
	000	r individual, facility-based			What Corrective Action(s) W		
	_	l exercise for 1 year following			Be Taken:		
	the onset of the actu	-			All residents have the potential	al to	
		itional exercise that may			be affected, no other resident		
	, ,	imited to the following:			were found to be affected by		
	a. A second full-sca	le exercise that is			alleged deficient practice. The		
	community-based o	r an individual, facility-based			facility will conduct an exercis		
	functional exercise.				test the facility's Emergency		
	b. A mock disaster				Preparedness Plan.		
	_	se or workshop that is led by a					
		des a group discussion, using			What Measures Will Be Put I	nto	
	-	y relevant emergency scenario,			Place and What Systemic		
		n statements, directed			Changes Will Be Made To		
		red questions designed to			Ensure That The Deficient		
	challenge an emerg				Practice Does Not Recur:		
		CC facility's response to and			The facility will conduct an		
	maintain documenta	ation of all drills, tabletop			exercise to test the facility's		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155743	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/28/2023
	ROVIDER OR SUPPLIER		501 N L	ADDRESS, CITY, STATE, ZIP COD LINCOLN AVE ER, IN 47944	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
K 0000	exercises, and emer LTC facility's emer accordance with 42 deficient practice of Findings include:  Based on record rev Administrator on 03 could not provide at full-scale exercise to annual individual, full-scale exercise or documentation according to the emergency plan could not provide duexercise that may infollowing: second functional exercise, tabletop exercise or facilitator that include a narrated, clinically and a set of problem messages, or preparinterview at the time. Administrator acknowledges and emerging interview at the time Administrator acknowledges.	gency events, and revise the gency plan, as needed in CFR 483.73(d)(2). This build affect all occupants.  Fiew with the facility 3/28/23 at 2:12 p.m., the facility my of the following: an annual that is community-based, an facility-based functional entation of an actual natural or cy that requires activation of a Furthermore, the facility occumentation on an additional aclude, but is not limited to the full-scale exercise that is ar an individual, facility-based a mock disaster drill, or a workshop that is led by a des a group discussion, using a relevant emergency scenario, an statements, directed and questions designed to ency plan. Based on an electron of of the facility owledged that no discussion of the facility owledged that no discussed with the Maintenance collity Administrator at the exit		Emergency Preparedness P The Maintenance Director w educated in regard to the po and procedure of conducting exercises annually to test the facility's Emergency Preparedness Plan.  How The Corrective Action Will Be Monitored To Ensur The Deficient Practice Will Recur: The Maintenance Director/Designee will monite completion of exercises to te facility's Emergency Preparedness Plan monthly 12 months, then every 6 mon thereafter. Any negative find will be corrected immediately forwarded to the Administrat report of progress will be for to the QAPI committee mont for a minimum of 6 months a the plan adjusted accordingly	lan. ill be licy 2 e (s) re Not  or the est the times onths ings / and or. A warded hly nd
Bldg. 01	A Life Safety Code	Recertification and State	K 0000	This plan of correction is to	
		as conducted by the Indiana		serve as Greenhill Manor	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155743		A. BU	(x2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			survey eted 2023	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 501 N LINCOLN AVE FOWLER, IN 47944				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	Department of Head 483.90(a).  Survey date: 03/28.  Facility Number: 0 Provider Number: 100.  At this Life Safety of Inc. was found not in Requirements for Power Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (I. Health Care Occupation of the C	287380  Code survey, Greenhill Manor in compliance with articipation in 42 CFR Subpart 483.90(a), re, and the 2012 edition of the ction Association (NFPA) 101, asC), Chapter 19, Existing ancies and 410 IAC 16.2.  Ity was determined to be of ruction and was fully cility has a fire alarm system on in the corridors, spaces is and hard-wired smoke at sleeping rooms 33 through ant rooms were equipped with oke detectors. The facility has I had a census of 26 at the time residents have customary ered and all areas providing the sprinklered.		TAG	Nursing and Rehabilitation Center's credible allegation of compliance. Submission of the 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.	of his he	DATE
K 0281 SS=F Bldg. 01							'

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLETE B. WING STREET ADDRESS, CITY, STATE, ZIP COD	ED
STREET ADDRESS, CITY, STATE, ZIP COD	
NAME OF PROVIDER OR SUPPLIER  501 N LINCOLN AVE FOWLER, IN 47944	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	(X5) COMPLETION DATE
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.  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 exit sould be controlled by a switch. Based on interview and observations at all of the exit doors, 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)  What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice. The facility will install automatic dusk-to-dawn lights at all six of the facility 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 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 sexit doors and the light switch at each exit will be covered with a light switch at each exit will be covered with a light switch at each exit will be covered with a light switch at each exit will be covered with a light switch at each exit will be covered with a light switch	04/27/2023

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The facility will install automatic dusk-to-dawn lights at all six of

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	OF CORRECTION	IDENTIFICATION NUMBER  155743	A. BUILDING B. WING	01	COMPLETED 03/28/2023
	ROVIDER OR SUPPLIER		501 N L	ADDRESS, CITY, STATE, ZIP COD LINCOLN AVE ER, IN 47944	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				the facility's exit doors and the light switch at each exit will be covered with a light switch pla The Maintenance Director will educated in regard to the regulation for Illumination of M of Egress.	te. be
				How The Corrective Action(s Will Be Monitored To Ensure The Deficient Practice Will N Recur: The Maintenance Director/Designee will monitor automatic dusk-to-dawn lights switch covers at each of the facility's exit doors weekly time months, then monthly times simonths, then quarterly therea Any negative findings will be corrected immediately and forwarded to the Administrator report of progress will be forw to the QAPI committee month for a minimum of 6 months and the plan adjusted accordingly.	ot  the and es 2 x fter.  r. A arded ly d
K 0321 SS=E Bldg. 01	barrier having 1-hd (with 3/4 hour fire automatic fire extin accordance with 8 approved automat option is used, the from other spaces	- Enclosure are protected by a fire our fire resistance rating rated doors) or an aguishing system in .7.1 or 19.3.5.9. When the ic fire extinguishing system areas shall be separated by smoke resisting is in accordance with 8.4.			

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155743	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 03/28/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 501 N LINCOLN AVE FOWLER, IN 47944				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	nonrated or field-a do not exceed 48 the door. Describe the floor hazardous areas t REMARKS. 19.3.2.1, 19.3.5.9  Area Separation a. Boiler and Fuel- b. Laundries (large c. Repair, Mainten d. Soiled Linen Ro gallons) e. Trash Collection (exceeding 64 gal f. Combustible Sto (over 50 square fe g. Laboratories (if Hazard - see K322 Based on observatio failed to ensure the hazardous areas, sur Keeping/Bio-hazard combustible supplie was provided with a would cause the doo latch into the door f could affect as many visitors.  Findings include:  Based on observatio facility on 03/28/23 Maintenance Direct resident rooms #28	ons) orage Rooms/Spaces et) classified as Severe 2) on and interview, the facility corridor door to 2 of over 8	K 0321	What Corrective Action(s) Was Accomplished For Those Residents Found To Have Baffected By The Deficient Practice:  No residents were affected by alleged deficient practice. The facility will install self-closing devices to resident rooms #28 #29 that are being used for storage.  How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified A What Corrective Action(s) Was Taken:	een  this  and		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		· ′	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		155743	B. WINC	·		03/28/	2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 501 N LINCOLN AVE FOWLER, IN 47944			
GREENH (X4) ID PREFIX TAG	SUMMARY  (EACH DEFICIEN  REGULATORY OR  including: recliners, dressers, bags of mi and other assorted of hazardous area. Bot over the 50 square f device being installe each of these conve by the Maintenance would have one inst soon as he could.  This item was discu	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION , wooden furniture and scellaneous clothing items, combustible items creating a th rooms also measured well feet. The lack of a self-closing ed on the corridor doors to red rooms was acknowledged Director who stated that he talled on each room door as assed with the Maintenance fility Administrator at the exit 8/23 at 2:30 p.m.	PR	FOWLE  ID  REFIX  TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIA DEFICIENCY)  All residents have the potential be affected, no other residents were affected by this alleged deficient practice. The facility winstall self-closing devices to resident rooms #28 and #29 th are being used for storage.  What Measures Will Be Put In Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur: The facility will install self-clos devices to resident rooms #28 #29 that are being used for storage. The Maintenance Dire will be educated in regard to th regulation for Hazardous Areas-Enclosures.  How The Corrective Action(s Will Be Monitored To Ensure The Deficient Practice Will No Recur: The Maintenance Director/Designee will monitor storage areas for self-closing devices monthly times 6 month then quarterly thereafter. Any negative findings will be correct immediately and forwarded to Administrator. A report of prog will be forwarded to the QAPI committee monthly for a minin of 6 months and the plan adjust	will hat hito ing and ector he hs, cted the press hum	(X5) COMPLETION DATE
K 0363 SS=E	NFPA 101 Corridor - Doors				accordingly.		

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155743	B. W	NG		03/28/	2023
			1	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	t			INCOLN AVE		
GRFFNH	IILL MANOR				ER, IN 47944		
					,		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	` ·	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCI		DATE
Bldg. 01	Corridor - Doors						
		corridor openings in other					
		losures of vertical openings,					
		s areas resist the passage					
		made of 1 3/4 inch					
		wood or other material					
	T	ng fire for at least 20					
	minutes. Doors in fully sprinklered smoke						
	•	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							
		hese requirements do not					
		spaces that do not contain					
	flammable or com						
		en bottom of door and floor					
	_	ceeding 1 inch. Powered					
	doors complying v	vith 7.2.1.9 are permissible					
	if provided with a	device capable of keeping					
	the door closed wi	hen a force of 5 lbf is					
	applied. There is	no impediment to the					
	closing of the door	rs. Hold open devices that					
	release when the	door is pushed or pulled are					
		ed protective plates of					
	unlimited height a	re permitted. Dutch doors					
	meeting 19.3.6.3.6	ି are permitted. Door					
	frames shall be lal	beled 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. Ir	n sprinklered compartments					
	there are no restri	ctions in area or fire					
	resistance of glass	s or frames in window					
	assemblies.						
	19.3.6.3, 42 CFR	Parts 403, 418, 460, 482,					
	483, and 485						
	Show in REMARK	S details of doors such as					
	fire protection ratir	ngs, automatics closing					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 01 COMP			
		155743	B. W	ING		03/28/2023	
NAME OF F	PROVIDER OR SUPPLIER	}		STREET .	ADDRESS, CITY, STATE, ZIP COD		
		•			LINCOLN AVE		
GREENH	HILL MANOR			FOWLE	ER, IN 47944		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		LETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	D <sub>2</sub>	ATE
	devices, etc.	on and interview, the facility	IZ O	262	Milest Commenting Action(s) Mi		7/2022
	Based on observation and interview, the facility failed to ensure 1 of 34 resident room doors to the		K 0	303	What Corrective Action(s) W Be Accomplished For Those	II 04/27/2023	
		se completely and latch into the			Residents Found To Have Bo		
		eficient practice could affect as			Affected By The Deficient	,en	
		ts, 3 staff, and 2 visitors.			Practice:		
		,-			No residents were affected by	this	
	Findings include:  Based on observations made during a tour of the facility on 03/28/23 at 12:48 p.m. with the				alleged deficient practice. The		
					corridor door to resident room		
					has been fixed to close prope	ly.	
	Maintenance Director, the corridor door to				How Other Residents Having	' I	
	resident room # 34 was extremely difficult to close				The Potential To Be Affected		
		interview at the time of			By The Same Deficient		
		Iaintenance Director			Practice Will Be Identified A		
	_	aforementioned condition and have swollen and that he would			What Corrective Action(s) W Be Taken:	"	
		on as he could so that it			All residents have the potential	ul to	
		much easier for the resident			be affected, no other residents		
	and staff.				were affected by this alleged		
					deficient practice. The corrido	r	
	This item was discu	ussed with the Maintenance			door to resident room #34 has		
		cility Administrator at the exit			been fixed to close properly.		
	conference on 03/28	8/23 at 2:30 p.m.			What Measures Will Be Put I	nto	
	3.1-19(b)				Place and What Systemic		
	5.1 17(0)			Changes Will Be Made To			
					Ensure That The Deficient		
					Practice Does Not Recur:		
					The corridor door to resident r	oom	
					#34 has been fixed to close		
					properly. The Maintenance		
					Director will be educated in re	-	
					to the regulation over corridor		
					doors.		
					How The Corrective Action(s	s)	
					Will Be Monitored To Ensure	•	
					The Deficient Practice Will N	ot	
					Recur:		

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	OF CORRECTION	IDENTIFICATION NUMBER  155743	A. BUILDING B. WING	<u>01</u>	COMPLETED 03/28/2023
	ROVIDER OR SUPPLIER		501 1	ET ADDRESS, CITY, STATE, ZIP COD N LINCOLN AVE /LER, IN 47944	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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 APPROPRIAL DEFICIENCY)	(X5) COMPLETION DATE
K 0521 SS=E	NFPA 101 HVAC			Maintenance Director/Designed will monitor proper closure of corridor doors monthly ongoing ensure proper closure. Any negative findings will be correct immediately and forwarded to Administrator. A report of progwill be forwarded to the QAPI committee monthly for a minimof 6 months and the plan adjust accordingly.	g to cted the ress
Bldg. 01	comply with 9.2 ar accordance with the specifications.  18.5.2.1, 19.5.2.1, Based on observation failed to ensure eggreat a portion of a return rooms for four of 62 conditioning, heating related equipment to with NFPA 90A, the of Air Conditioning NFPA 90A, Section corridors in nursing shall not be used as or exhaust air system unless otherwise per 4.3.12.1.3.4. This domain as 20 resident Findings include:		K 0521	What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Be Affected By The Deficient Practice:  No residents were affected by alleged deficient practice. Retrair vents will be installed in the MDS office, the SSD office, the Housekeeping/Laundry office, the laundry room.  How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified Ar What Corrective Action(s) Will Be Taken:  All residents have the potential be affected, no other residents	this urn e e and  I I I I I I I I I I I I I I I I I I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPLETED	
		155743	B. WI	NG	_	03/28/	2023
NAME OF T	DDOMINED OD GUIDDI TER		-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIER	•			INCOLN AVE		
GREENH	HILL MANOR			FOWLE	ER, IN 47944		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		to 1:24 p.m., the following ne egress corridor as a return			were affected by this alleged	onto	
	air system:	ie egress corridor as a return			deficient practice. Return air v will be installed in the MDS off		
	a) The Housekeeping / Laundry office. b) The MSD office.				the SSD office, the	iice,	
					Housekeeping/Laundry office,	and	
	c) The social servic				the laundry room.		
	d) The Laundry roo						
	Based on interview at the time of the observations, the Maintenance Director				What Measures Will Be Put I	nto	
					Place and What Systemic		
	_	forementioned room and			Changes Will Be Made To		
	support offices were using the egress corridor as				Ensure That The Deficient		
	a return air system.				Practice Does Not Recur:  Return air vents will be installed	ad in	
	This item was discussed with the Maintenance Director and the facility Administrator at the exit				the MDS office, the SSD office		
					the Housekeeping/Laundry of	-	
	conference on 03/28	-			and the laundry room. The	,	
		•			Maintenance Director will be		
	3.1-19(b)				educated in regard to the		
					regulation for HVAC-Ventilation	n.	
					How The Corrective Action(s	5)	
					Will Be Monitored To Ensure		
					The Deficient Practice Will N	ot	
					Recur:		
					Maintenance Director/Designe		
					will monitor offices for return a ventilation monthly times 6	ur	
					months, then bi-annually		
					thereafter. Any negative findin	ias	
					will be corrected immediately	-	
					forwarded to the Administrator		
					report of progress will be forwa	arded	
					to the QAPI committee month	-	
					for a minimum of 6 months an		
					the plan adjusted accordingly.		
K 0522	NFPA 101						
SS=E	HVAC - Any Heati	ng Device					
Bldg. 01	HVAC - Any Heati	ng Device					
	Any heating devic	e, other than a central					

	OF CORRECTION	IDENTIFICATION NUMBER  155743	A. BUILDING B. WING	G <u>01</u>	COMPLETED 03/28/2023
	PROVIDER OR SUPPLIER		501	EET ADDRESS, CITY, STATE, ZIP COD N LINCOLN AVE WLER, IN 47944	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE APPROP	COMPLETION
	combustible mater device, and has a and shut down equexcessive temperature fuel fired, the device is chimney or verestakes air for come provides for a confrom occupied are 19.5.2.2 Based on observation failed to ensure 1 of provided with intake outside for rooms occupied are 19.5.2.2 Based on observation failed to ensure 1 of provided with intake outside for rooms occupied are 19.5.2.2 Based on observation with carbon more physical problems for Findings include:  Based on observation facility on 03/28/23 Maintenance Direct fuel fired dryers. Based where the outside air none could be located by the Maintenance observation who state one as soon as he could be confused in the provided with the maintenance of the could be confused air none could be located by the Maintenance observation who state one as soon as he could be confused in the provided with the provided air none could be located by the Maintenance observation who state one as soon as he could be confused in the provided with the provided air none could be located by the Maintenance observation who stated the provided with the provided air none could be located by the Maintenance observation who stated the provided with the provided air none could be located by the Maintenance observation who stated the provided with the provided	ature or ignition failure. If ce also: nt connected. bustion from outside. bustion system separate a atmosphere.  on and interview, the facility full laundry rooms was e combustion air from the ontaining fuel fired equipment. dice could create an atmosphere onoxide which could cause for all staff in the laundry room.  ons made during a tour of the at 12:15 p.m. with the or, the laundry room had two ased on interview, when asked it source for the dryers was, ed. This was acknowledged Director at the time of atted that he would have to add build.  ssed with the Maintenance cility Administrator at the exit	K 0522	What Corrective Action(s) Be Accomplished For Those Residents Found To Have Affected By The Deficient Practice: No residents were affected alleged deficient practice. A air intake will be installed in laundry room.  How Other Residents Havi The Potential To Be Affect By The Same Deficient Practice Will Be Identified What Corrective Action(s) Be Taken: All residents have the potent be affected, no other reside were affected by this alleged deficient practice. A fresh ai intake will be installed in the laundry room.  What Measures Will Be Pu Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur: A fresh air intake will be installed in the	se Been  by this fresh the  ng ed  And Will tial to ents ed  r es  t Into

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	OF CORRECTION	IDENTIFICATION NUMBER  155743	A. BUILDING B. WING	01	COMPLETED 03/28/2023
	PROVIDER OR SUPPLIER		501 N I	ADDRESS, CITY, STATE, ZIP COD LINCOLN AVE ER, IN 47944	į.
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	COMPLETION
				in the laundry room. The Maintenance Director will be educated in regard to the requirements for fresh air in  How The Corrective Action Will Be Monitored To Ensure The Deficient Practice Will Recur:  Maintenance Director/Design will monitor fresh air intakes monthly times 6 months, the quarterly times 2 quarters, the annually ongoing. Any negating findings will be corrected immediately and forwarded	takes.  n(s) Ire Not Inee Sen hen hen
K 0741 SS=E Bldg. 01	shall include not le provisions: (1) Smoking shall ward, or compartm liquids, combustibl used or stored and location, and such signs that read NC posted with the int smoking. (2) In health care of smoking is prohibit prominently placed.	ons ons shall be adopted and ess than the following be prohibited in any room, ment where flammable the gases, or oxygen is do in any other hazardous area shall be posted with o SMOKING or shall be the ernational symbol for no occupancies where		Administrator. A report of pr will be forwarded to the QAF committee monthly for a mir of 6 months and the plan ac accordingly.	rogress Pl nimum

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í		ONSTRUCTION	ľ ′	ATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 01 COMPLETED				
		155743	B. W	ING		03/28	/2023	
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD LINCOLN AVE			
GREEN	HILL MANOR				ER, IN 47944			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	smoking shall not							
		atients classified as not						
	responsible shall	*						
		ent of 18.7.4(3) shall not						
		patient is under direct						
	supervision.							
	(5) Ashtrays of noncombustible material and							
	safe design shall be provided in all areas where smoking is permitted.						1	
	(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							
		on and interview, the facility	K 0	741	What Corrective Action(s) W	'ill	04/27/2023	
		f 1 area where smoking was	110	,	Be Accomplished For Those		0 1/2//2023	
		and residents was maintained in			Residents Found To Have B			
	_	.7.4. LSC 19.7.4 requires			Affected By The Deficient			
	ashtrays of noncom	bustible material and safe			Practice:			
	design shall be pro-	vided in all areas where			No residents were affected by	this		
	smoking is permitte	ed. Metal containers with a			alleged deficient practice.			
	self-closing cover of	levices into which ashtrays			Cigarette butts have been cle	aned		
	can be emptied sha	ll be readily available to all			up at the employee entrance	near		
	areas were smoking	g is permitted. This deficient			the kitchen.			
	practice could affect	et staff only.					1	
					How Other Residents Having	-		
	Findings include:				The Potential To Be Affected	l		
		ta a sec.			By The Same Deficient	_	1	
		ons with the Maintenance			Practice Will Be Identified A			
		7 at 11:28 a.m., there were			What Corrective Action(s) W	'ill		
		o 50 cigarette butts on the			Be Taken:			
		kitchen entrance near the			All residents residing in the fa	-		
	_ ~	n interview at the time of			have the potential to be affect			
	· ·	aintenance Director			no other residents were affect		1	
		40 to 50 cigarette butts on the			by this alleged deficient practi		1	
		byee entrance and stated that			Cigarette butts have been cle			
		oproved container in the area every smoker use it.			up at the employee entrance	ıear	1	
	out could not make	every smoker use it.			the kitchen.			
	This item was discu	ussed with the Maintenance			What Measures Will Be Put I	nto		

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PRINTED: 04/19/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155743		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 03/28/2023			
	PROVIDER OR SUPPLIEI	<b>R</b>	STREET ADDRESS, CITY, STATE, ZIP COD 501 N LINCOLN AVE FOWLER, IN 47944				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY 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	Director and the fac conference on 03/2 3.1-19(b)	ELSC IDENTIFYING INFORMATION cility Administrator at the exit 8/23 at 2:30 p.m.		TAG	Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur: Cigarette butts have been cle up at the employee entrance the kitchen. All staff including the Mainten Director will be educated in re to the requirement of proper cigarette disposal.  How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will N Recur: Maintenance Director/Design will monitor designated smok areas daily on scheduled workdays times 30 days, ther weekly ongoing. Any negative findings will be corrected immediately and forwarded to Administrator. A report of pro- will be forwarded to the QA Committee monthly for a mini of 6 months and the plan adju- accordingly.	near lance legard  s) le lot lee ling  the lee lothe ling limum	DATE
K 0751 SS=E Bldg. 01	Fabr Draperies, Curtain Fabrics Draperies, curtain and loosely hangi accordance with and draperies: at windows in patien	ns, and Loosely Hanging ns, and Loosely Hanging s including cubicle curtains ng fabric or films shall be in 10.3.1. Excluding curtains showers and baths; on it sleeping room located in artments; and in non-patient					

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		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/28/2023	
	ROVIDER OR SUPPLIER		501 N	ADDRESS, CITY, STATE, ZIP COD LINCOLN AVE ER, IN 47944	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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)	
TAG	sleeping rooms in where individual d not exceed 48 squ not exceed 20 per 18.7.5.1, 18.3.5.1 10.3.1 Based on observation failed to provide a function that showed curtain Therapy area were incomplied with NFP Fire Tests for Flame Films. NFPA 101 L 19.7.5.1 states: Drayloosely hanging fab furnishings or deconoccupancies shall be provisions of 10.3.1 following also shall curtains shall not in other rooms or area curtains comply with Individual drapery dexceed 48 square fee could affect as man visitor in the facility. Findings include:  Based on observation facility on 03/28/23 Maintenance Direct curtains hanging in curtains extended from the observation of the observation o	In the street of	K 0751		dill 04/27/2023 een 04/27/2023 een 04/27/2023 dill 04/27/2023
	NFPA 701 standard	s for curtains in a healthcare nance Director answered no,		with a flame-retardant chemic The Maintenance Director will	al.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155743		(X2) MULTIPLE C A. BUILDING B. WING	<u></u>		
	PROVIDER OR SUPPLIER		501 N	ADDRESS, CITY, STATE, ZIP COD LINCOLN AVE ER, 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 APPROPRIADEFICIENCY)	(X5) COMPLETION DATE
me	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)		1710	spray the curtains bi-annually appropriate documentation wi maintained. The Maintenance Director will be educated in reto the regulation for Draperies Curtains, and Loosely Hangin Fabrics.	and Il be gard
				How The Corrective Action(s Will Be Monitored To Ensure The Deficient Practice Will N Recur: Maintenance Director/Designe will monitor the curtains locate the Therapy room for flame-retardant spray and appropriate documentation of quarterly times 2 quarters, the bi-annually thereafter. Any negative findings will be corre immediately and forwarded to Administrator. A report of prog will be forwarded to the QA Committee monthly for a mini of 6 months and the plan adjut accordingly.	ot  ee ed in  such en cted the gress mum
K 0781 SS=E Bldg. 01	prohibited in all he except, unless use employee areas w				
	Based on record rev interview; the facili	riew, observation, and ty failure to ensure 1 of 1 ers in use was compliant with	K 0781	What Corrective Action(s) W Be Accomplished For Those Residents Found To Have B	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COM		COMPL	COMPLETED	
		155743	B. WING		03/28/	03/28/2023	
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
ODEENWILL MANAGE					LINCOLN AVE		
GREENE	IILL MANOR		FOWLER, IN 47944				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDERS PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	the facility's space l	neather policy. This deficient			Affected By The Deficient		
	practice could affec	t as many as 10 residents, 4			Practice:		
	staff and 2 visitors.				No residents were affected by	this	
					alleged deficient practice. The		
	Findings include:				portable space heater was		
	C				removed from the Business O	ffice	
	Based on observation	ons made during a tour of the			in the facility.		
		at 12:01 p.m. with the					
		or, a portable space heater			How Other Residents Having	,	
		in the Business office.			The Potential To Be Affected		
		umentation affixed to the			By The Same Deficient		
	portable space heate	er did not state the maximum			Practice Will Be Identified Ar	nd	
	temperature achieved by the unit. Based on				What Corrective Action(s) W		
	interview at the time of observation, the				Be Taken:		
	Maintenance Director stated portable space				All residents residing in the fac	cility	
	heaters are allowed to be used in the facility but				have the potential to be affect		
	acknowledged that he had no documentation to				no other residents were affect		
	show that this portable space heater met the				by this alleged deficient practi		
	requirements set forth in the facility's space heater				The portable space heater wa		
	policy. Based on review of facility policy entitled "Portable Electrical Heaters Policy" documentation, it is clearly stated that the heating				removed from the Business O		
					in the facility.		
					,		
	element of said space	ce heaters can not exceed 212			What Measures Will Be Put I	nto	
	degrees Fahrenheit (100 degrees Celsius)				Place and What Systemic		
					Changes Will Be Made To		
	This item was discu	ssed with the Maintenance			Ensure That The Deficient		
	Director and the fac	cility Administrator at the exit			Practice Does Not Recur:		
	conference on 03/28	8/23 at 2:30 p.m.			The portable space heater wa	s	
					removed from the Business O		
	3.1-19(b)				in the facility. All staff including	g	
					the Maintenance Director will	be	
					educated in regard to the space	се	
					heater policy and procedure.		
					How The Corrective Action(s	i)	
					Will Be Monitored To Ensure	,	
					The Deficient Practice Will N	ot	
					Recur:		
					Maintenance Director/Designe	e	
					will monitor all areas of the fac	cility	

(X5)
COMPLETION DATE
04/27/2023

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			COMPL	COMPLETED	
		155743	B. WING 03/2		03/28/	03/28/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					LINCOLN AVE		
GREENHILL MANOR			FOWLER, IN 47944				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1	y charger is malfunctioning.			All residents have the potentia		
	1 1	al signals plus a common			be affected, no other residents	3	
	audible signal to warn of an engine-generator				were affected by this alleged		
	alarm condition shall indicate:				deficient practice. The generator		
	a. Low lubricating				will be connected to the facility		
	b. Low water temp				remote annunciator.	remote annunciator.	
	c. Excessive water				,		
		the main fuel storage tank			What Measures Will Be Put Into		
		4-hour operating supply.			Place and What Systemic		
	e. Overcrank (faile	d to start).			Changes Will Be Made To		
	f. Overspeed.	1 4 4 2 2011 44 1 1			Ensure That The Deficient		
	_	orkstation will be unattended			Practice Does Not Recur:	1 4 -	
	periodically, an audible and visual derangement signal, appropriately labeled, shall be established				The generator will be connect		
		-			the facility remote annunciator.  The Maintenance Director will be		
	at a continuously monitored location. This					be	
	derangement signal shall activate when any of the				educated in regard to the	_	
	conditions in 6.4.1.1.17(1) and (2) occur but need				requirements for the generato	ſ	
	not display these conditions individually. This				annunciator panel.		
	deficient practice could affect all patients, as well				How The Corrective Action(s		
	as staff and visitors in the facility.				Will Be Monitored To Ensure	-	
	Findings include:				The Deficient Practice Will N		
	i manigs metade.				Recur:	Οί	
	Based on interview	during record review on			Maintenance Director/Designe	20	
					will monitor the generator		
	03/28/23 at 10:12 a.m., the EOC Maintenance Director said the facility has a replacement				annunciator panel monthly		
	emergency generator while management				ongoing. Any negative finding	s will	
	determined what to do with the facility generator				be corrected immediately and	C 17111	
	that had stopped working. Based on observations				forwarded to the Administrator	r. A	
		of the facility, the annunciator			report of progress will be forw		
		urse's station was still			to the QAPI committee month		
	_	oken generator, therefore the			for a minimum of 6 months an	•	
		t generator did not have a			the plan adjusted accordingly.		
		sly monitored annunciator			, , ,		
		d on an interview at the time of					
		Maintenance Director agreed					
		ergency generator was not					
		uously monitored annunciator					
		ould advise his management					
	_	compliant as soon as	1				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01		(X3) DATE SURVEY COMPLETED		
		155743	B. WING		03/28/2023		
NAME OF PROVIDER OR SUPPLIER  GREENHILL MANOR			STREET ADDRESS, CITY, STATE, ZIP COD 501 N LINCOLN AVE FOWLER, IN 47944				
(X4) ID	SUMMARY	MARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECT		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION		
TAG			TAG	DEFICIENCY)		DATE	
		ssed with the Maintenance ility Administrator at the exit 3/23 at 2:30 p.m.					

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