

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

PRINTED: 07/17/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155524</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C 07/15/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>HEALTH CENTER AT GLENBURN HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>618 W GLENBURN ROAD LINTON, IN 47441</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for Investigation of Complaints IN00327132, IN00327426, IN00327433, IN00327439, IN00327472. This visit included a COVID-19 Focused Infection Control Survey.</p> <p>Complaint IN00327132 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00327426 - Substantiated. No deficiencies related to the allegation(s) are cited.</p> <p>Complaint IN00327433 - Substantiated. No deficiencies related to the allegation(s) are cited.</p> <p>Complaint IN00327439 - Substantiated. No deficiencies related to the allegation(s) are cited.</p> <p>Complaint IN00327472 - Substantiated. No deficiencies related to the allegation(s) are cited.</p> <p>Survey dates: July 14, and 15, 2020.</p> <p>Facility number: 000230 Provider number: 155524 AIM number: 100275000</p> <p>Census Bed Type: SNF/NF: 86 SNF: 5 Total: 91</p> <p>Census Payor Type: Medicare: 5 Medicaid: 72 Other: 14 Total: 91</p> <p>Health Center At Glenburn Home was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00327132,</p>	F 000		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1  IN00327426, IN00327433, IN00327439, IN00327472 and the COVID-19 Focused Infection Control Survey.  Quality Review completed on July 16, 2020.		F 000		