PRINTED: 10/25/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039									
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155524	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/01/2024				
NAME OF PROVIDER OR SUPPLIER HEALTH CENTER AT GLENBURN HOME			618 W	ADDRESS, CITY, STATE, ZIP COD GLENBURN ROAD N, IN 47441					
(X4) ID PREFIX TAG F 0000	(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE				
F 0641 SS=D	Licensure Survey. Survey dates: Septe October 1, 2024 Facility number: 00 Provider number: 1 AIM number: 1002 Census Bed Type: SNF/NF: 92 SNF: 5 Total: 97 Census Payor Type Medicare: 6 Medicaid: 73 Private: 18 Total: 97 These deficiencies accordance with 41	reflect State Findings cited in 0 IAC 16.2-3.1. appleted October 4, 2024.	F 0000	The submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forthe the Statement of Deficiencies. The Plan of Correction is prepand submitted because of the requirement under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance. Pleafind enclosed the Plan of Correction for this survey. Duthe low scope and severity of survey findings, please find sufficient documentation provievidence of compliance with the Plan of Correction. The documentation serves to confit the facility's allegation of compliance. Thus, the facility respectfully requests the grant of a desk review and paper compliance. Should additional information be necessary to confirm said compliance, pleafeel free to contact me. Respectfully submitted, Jean Johanningsmeier, RN, H. Chief Operating Officer	ase ue to the iding the irm iting al				
Bldg. 00		and record review, the facility	F 0641	F641	10/25/2024				

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

TITLE

(X6) DATE 10/17/2024

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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Jean Johanningsmeier

RN, HFA, COO

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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 COMPLETED 00 B. WING 10/01/2024 155524 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 618 W GLENBURN ROAD HEALTH CENTER AT GLENBURN HOME **LINTON. IN 47441** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE failed to ensure the accuracy of the Minimum Data The corrective action taken for Set (MDS) assessment for 1 of 1 residents those residents found to have reviewed for Resident Assessment. (Resident 40) been affected by the deficient practice is: A modification of the Finding includes: identified MDS found to be deficient was corrected and During an interview on 9/26/24 at 10:51 a.m., resubmitted to the Centers for Resident 40 indicated she had limitation of her Medicare and Medicaid Services upper and lower extremities and staff assisted her (CMS). with range of motion (ROM) exercise. The corrective action taken for those residents who have the On 9/30/24 at 3:15 p.m., Resident 40's clinical potential to be affected by the record was reviewed. The diagnoses included, but deficient practice: All residents were not limited to, cerebral infarction (stroke), have the potential to be affected right side hemiparesis (partial paralysis on one by this deficient practice, thus the side of the body), and contracture (shortening of following corrective actions have muscles that causes joints to stiffen). been taken; An internal audit, per the plan of correction, of MDS The Annual MDS assessment, dated 9/6/24, assessments will be conducted indicated Resident 40 was cognitively intact, had prior to submission to ensure impairment on one side of her upper and lower compliance with coding extremity, had no days that PROM was preformed requirements and identifying for at least 15 minutes a day, and had no days that potential errors. AAROM was performed for at least 15 minutes a The measures that have been put into place to ensure that the deficient practice does not recur The Passive Range of Motion (PROM) Report, is: As a means of ongoing dated 9/1/24-10/1/24, indicated the following: compliance, MDS Staff will receive training regarding the importance - On 9/3/24 at 2:59 p.m., Resident 40 had 15 of accuracy of MDS coding, (See minutes of PROM. Attachment A). Ongoing education will be provided - On 9/4/24 at 2:59 p.m., Resident 40 had 15 quarterly to ensure staff are kept minutes of PROM. up to date on any changes to MDS coding requirements. -On 9/5/24 at 2:59 p.m., Resident 40 had 15 minutes The corrective action taken to of PROM. monitor to ensure the deficient practice will not recur is: As a The Active Assisted Range of Motion (AAROM) means of quality assurance, the

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Report, dated 9/1/24-10/1/24, indicated the

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administrator or designee will

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRU		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
1555		155524	B. WING		10/01/2024		
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					GLENBURN ROAD		
HEALTH CENTER AT GLENBURN HOME					N, IN 47441		
	CERTER AND CEEP				.,		ı
(X4) ID		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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)	:4 -	DATE
	following:					onduct MDS submission audits	
	On 0/2/24 at 2.50	n m. Dagidant 40 had 15			on 2 assessments weekly times 4 weeks; then once weekly times three months; then once monthly until compliance is maintained for		
	minutes of AARON	p.m., Resident 40 had 15					
	minutes of AARON	/1.					
	On 9/4/24 at 2:50 t	o.m., Resident 40 had 15 minutes			2 consecutive quarters. The	101	
	of AAROM.	, resident to mad 15 minutes			results of the audits will be		
					reviewed during monthly Qual	itv	
	-On 9/5/24 at 2:59 t	o.m., Resident 40 had 15 minutes			Assurance/Performance	,	
	of AAROM.				Improvement meetings with the		
					plan of action adjusted		
	The Restorative Nursing Progress Notes, dated 9/6/24, indicated Resident 40 received AAROM and PROM restorative program three times a				accordingly, as warranted, (Se	ee	
					Attachment B).		
					The above corrective actions v		
	week.				be completed on or before Oc	tober	
		10/1/04 + 2.25			25, 2024.		
	_	v on 10/1/24 at 9:35 a.m., the					
	MDS Coordinator indicated the MDS assessment should of been coded for the three days Resident 40 received PROM and AAROM. On 10/1/24 at 3:42 p.m., the Assistant Director of Nursing (ADON) indicated they did not have a MDS assessment coding policy. They followed the Resident Assessment Instrument (RAI)						
		the MDS assessment.					
	3.1-31(d)						
F 0695	483.25(i)	_					
SS=D		eostomy Care and					
Bldg. 00	Suctioning			60. 5	5005		10/05/2024
		on, record review, and	F 06	595	F695	_	10/25/2024
		ty failed to provide respiratory lents reviewed for oxygen			The corrective action taken for	Г	
		bing and humidification water			those residents found to have been affected by the deficient		
					practice is: The identified unda	ated	
	bottles were not labeled with a date. (Resident 26)				oxygen tubing and humidificat		
	Finding includes:				bottle were immediately replace		
	<i></i>				with new, appropriately labele		

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NAME OF PROVIDER OR SUPPLIER HEALTH CENTER AT GLENBURN HOME			STREET ADDRESS, CITY, STATE, ZIP COD 618 W GLENBURN ROAD LINTON, IN 47441				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
TAG	On 9/26/24 at 10:15 observed lying in be administered via na There was no date of humidification water On 9/26/24 at 1:52 lying in bed with Of 4 L. There was no conformal or humidification with Of 1 L. There was no conformal of the NC tubing or humidification with On 9/27/24 at 10:30 observed standing a administered at 4 L. the NC tubing or humidification with On 9/30/24 at 9:15 lying in bed with or date observed on the bottle. On 10/1/24 at 9:49 lying in bed with or There was no date of humidification water on 9/27/24 12:51 p was reviewed. The limited to, Chronic (COPD), Type 2 did The quarterly Minimassessment, dated 7 received oxygen the Resident 26 had oxyrespiratory illness.	sa.m., Resident 26 was ed with oxygen (O2) being sal cannula (NC) at 4 liters (L). Observed on the NC tubing or er bottle. p.m., Resident 26 was observed 2 being administered via NC at late observed on the NC tubing rater bottle. D. a.m., Resident 26 was to bedside with oxygen being via NC, no date observed on unidification water bottle. a.m., Resident 26 was observed oxygen in use. There was no e NC or humidification water a.m., Resident 26 was observed oxygen in place at 4 L via NC. Observed on the NC or er bottle. m.m., Resident 26's clinical record diagnoses included, but not Obstructive Pulmonary Disease abetes mellitus, and dementia. mum Data Set (MDS) 1/5/24, indicated Resident 26		TAG	oxygen supplies. The corrective action taken fo those residents found to have been affected by the deficient practice is: All residents who utilize oxygen have the potent be affected by this deficient practice, thus the following corrective actions have been taken; an audit was completed ensure all oxygen supplies in were properly dated, (See Attachment C). The measures that have been into place to ensure that the deficient practice does not redis: As a means of ongoing compliance education was provided to all staff members involved in the handling, replacement and monitoring of oxygen supplies, (See Attachment C). New labeling tags were implemented to be used with a oxygen supplies upon opening use. Visual reminders have a been placed in supply storage areas as a reminder of dating procedures. The corrective action taken to monitor to ensure the deficient practice will not recur is: As a means of quality assurance, the Administrator or Designee will conduct audits to ensure datir compliance of oxygen supplie weekly times 4 weeks; then monthly times 3 months; then	r ial to d to use put sur fer ating ment lso t	DATE

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(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)	TE	(X5) COMPLETION DATE
F 0921 SS=E	A physician's order titrate oxygen to kee 92% on 2-5L per No A physician's order tubing and humidification in the shift every Friendly and interview Director of Nursing had current order for indicated that they obtained the date shand bottle. The DO noted on nasal cannowater bottle. On 10/1/24 at 2:30 Nursing (ADON) p "Oxygen Administr indicated it was a pereview of the policy perform hand hygical administering oxygen measures include: mask/cannula week bottle every 72 hour recommended by masures include:	dated 4/15/24, indicated ep saturations greater than C every shift. dated 9/6/24, indicated O2 and water change every week, day for oxygen usage. on 10/1/24 at 10:20 a.m., the (DON) indicated Resident 26 for oxygen therapy. The DON changed the tubing and de each week. The DON mould be written on the tubing N indicated there was no date ula tubing and humidification p.m., the Assistant Director of rovided the facility policy, ation," dated 1/8/24, she olicy currently being used. A or indicated, "5. Staff shall me and don gloves when enOther infection control b. change oxygen tubing and lyc. change humidification rs or per facility policy, or as			quarterly until compliance is maintained for 2 consecutive quarters. The results of the au will be reviewed during month Quality Assurance/Performand Improvement meetings with the plan of action adjusted accordingly, as warranted, (See Attachment E). The above corrective actions to be completed on or before Oc 25, 2024.	ly ce ee will	
Bldg. 00	review, the facility	on, interview, and record failed to ensure sit to stand lift clean for 4 of 4 sit to stand	F 09	921	F921 The corrective action taken for those residents found to have		10/25/2024

lifts observed.

been affected by the deficient

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/01/2024 155524 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 618 W GLENBURN ROAD HEALTH CENTER AT GLENBURN HOME **LINTON. IN 47441** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE practice is: No residents were Findings include: affected by this deficient practice. The identified sit-to-stand lifts were 1. On the following dates and times, a immediately cleaned. non-mechanized sit to stand lift was observed in The corrective action taken for the hallway outside of Room 504 with the foot those residents who have the platform containing food crumbs and debris: potential to be affected by the deficient practice: All residents - On 9/27/24 at 10:10 a.m. who utilize a sit-to-stand lift have - On 9/30/24 at 1:20 p.m. the potential to be affected by this - On 10/1/24 at 11:45 a.m. deficient practice, thus the following corrective actions have 2. On the following dates and times, a been taken; an inspection of all non-mechanized sit to stand lift was observed in sit-to-stand lifts was completed to the hallway outside of Room 612 with the foot ensure the equipment is free of platform containing food crumbs and debris: debris and soilage, (See Attachment F). - On 9/27/24 at 10:20 a.m. The measures that have been put - On 9/30/24 at 1:30 p.m. into place to ensure that the - On 10/1/24 at 11:55 a.m. deficient practice does not recur is: As a means of ongoing 3. On the following dates and times, a mechanized compliance education was sit to stand lift was observed in the hallway provided to all direct care staff outside of Room 610 with the foot platform involved in the use of sit-to-stand containing food crumbs and debris: lifts regarding proper cleaning procedures for equipment, (See - On 9/27/24 at 10:25 a.m. Attachment D). A cleaning - On 9/30/24 at 1:35 p.m. schedule will be implemented to - On 10/1/24 at 11:58 a.m. ensure ongoing cleanliness. The corrective action taken to 4. On the following dates and times, a monitor to ensure the deficient non-mechanized sit to stand lift was observed in practice will not recur is: As a the hallway next to the Unit 500 soiled utility room means of quality assurance the with the foot platform containing food crumbs and Administrator or Designee will debris: monitor to ensure cleanliness of sit-to-stand lifts weekly x 4 weeks, - On 9/27/24 at 10:30 a.m. then monthly x 3 months, then

- On 9/30/24 at 1:40 p.m.

- On 10/1/24 at 12:02 .p.m..

quarterly until compliance is

maintained for 2 consecutive quarters. The results of the audits

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

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(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	During an interview on 10/1/24 at 3:00 p.m., the				will be reviewed during monthly		
	Administrator indicated the foot platforms of the				Quality Assurance/Performance		
	sit to stand lifts were in need of cleaning before				Improvement meetings with the		
	resident use.			plan of action adjusted			
	On 10/1/24 at 3:40 p.m., the Assistant Director of Nursing provided the Resident Rights, revised date 3/5/24, and indicated this was the Resident Rights policy used by the facility. A review of the policy indicated, "the resident has the right to a safe, clean, comfortable and homelike environment" 3.1-19(f)			accordingly, as warranted, (See Attachment G). The above corrective actions will be completed on or before October 25, 2024.		vill	

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