STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155524	A. BUILDING 00 B. WING	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTH CENTER AT GLENBURN HOME	618 W GLENBURN ROAD LINTON, IN 47441

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: September 25, 26, 27, 30, and October 1, 2024 Facility number: 000230 Provider number: 155524 AIM number: 100275000 Census Bed Type: SNF/NF: 92 SNF: 5 Total: 97 Census Payor Type: Medicare: 6 Medicaid: 73 Private: 18 Total: 97 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 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 forth on the Statement of Deficiencies. The Plan of Correction is prepared and submitted because of the requirement under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance. Please find enclosed the Plan of Correction for this survey. Due to the low scope and severity of the survey findings, please find sufficient documentation providing evidence of compliance with the Plan of Correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of a desk review and paper compliance. Should additional information be necessary to confirm said compliance, please feel free to contact me. Respectfully submitted, Jean Johanningsmeier, RN, HFA Chief Operating Officer	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments Based on interview and record review, the facility	F 0641	F641	10/25/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jean Johanningsmeier	RN, HFA, COO	10/17/2024

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	failed to ensure the accuracy of the Minimum Data Set (MDS) assessment for 1 of 1 residents reviewed for Resident Assessment. (Resident 40) Finding includes: During an interview on 9/26/24 at 10:51 a.m., Resident 40 indicated she had limitation of her upper and lower extremities and staff assisted her with range of motion (ROM) exercise. On 9/30/24 at 3:15 p.m., Resident 40's clinical record was reviewed. The diagnoses included, but were not limited to, cerebral infarction (stroke), right side hemiparesis (partial paralysis on one side of the body), and contracture (shortening of muscles that causes joints to stiffen). The Annual MDS assessment, dated 9/6/24, indicated Resident 40 was cognitively intact, had impairment on one side of her upper and lower extremity, had no days that PROM was preformed for at least 15 minutes a day, and had no days that AAROM was performed for at least 15 minutes a day. The Passive Range of Motion (PROM) Report, dated 9/1/24-10/1/24, indicated the following: - On 9/3/24 at 2:59 p.m., Resident 40 had 15 minutes of PROM. - On 9/4/24 at 2:59 p.m., Resident 40 had 15 minutes of PROM. -On 9/5/24 at 2:59 p.m., Resident 40 had 15 minutes of PROM. The Active Assisted Range of Motion (AAROM) Report, dated 9/1/24-10/1/24, indicated the		The corrective action taken for those residents found to have been affected by the deficient practice is: A modification of the identified MDS found to be deficient was corrected and resubmitted to the Centers for Medicare and Medicaid Services (CMS). The corrective action taken for those residents who have the potential to be affected by the deficient practice: All residents have the potential to be affected by this deficient practice, thus the following corrective actions have been taken; An internal audit, per the plan of correction, of MDS assessments will be conducted prior to submission to ensure compliance with coding requirements and identifying potential errors. The measures that have been put into place to ensure that the deficient practice does not recur is: As a means of ongoing compliance, MDS Staff will receive training regarding the importance of accuracy of MDS coding, (See Attachment A). Ongoing education will be provided quarterly to ensure staff are kept up to date on any changes to MDS coding requirements. 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	

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	following: - On 9/3/24 at 2:59 p.m., Resident 40 had 15 minutes of AAROM. -On 9/4/24 at 2:59 p.m., Resident 40 had 15 minutes of AAROM. -On 9/5/24 at 2:59 p.m., Resident 40 had 15 minutes of AAROM. The Restorative Nursing Progress Notes, dated 9/6/24, indicated Resident 40 received AAROM and PROM restorative program three times a week. During an interview 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) manual for coding the MDS assessment. 3.1-31(d)		conduct MDS submission audits on 2 assessments weekly times 4 weeks; then once weekly times three months; then once monthly until compliance is maintained for 2 consecutive quarters. The results of the audits will be reviewed during monthly Quality Assurance/Performance Improvement meetings with the plan of action adjusted accordingly, as warranted, (See Attachment B). The above corrective actions will be completed on or before October 25, 2024.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review, and interview, the facility failed to provide respiratory care for 1 of 3 residents reviewed for oxygen therapy. Oxygen tubing and humidification water bottles were not labeled with a date. (Resident 26) Finding includes:	F 0695	F695 The corrective action taken for those residents found to have been affected by the deficient practice is: The identified undated oxygen tubing and humidification bottle were immediately replaced with new, appropriately labeled	10/25/2024

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	On 9/26/24 at 10:15 a.m., Resident 26 was observed lying in bed with oxygen (O2) being administered via nasal cannula (NC) at 4 liters (L). There was no date observed on the NC tubing or humidification water bottle. On 9/26/24 at 1:52 p.m., Resident 26 was observed lying in bed with O2 being administered via NC at 4 L. There was no date observed on the NC tubing or humidification water bottle. On 9/27/24 at 10:30 a.m., Resident 26 was observed standing at bedside with oxygen being administered at 4 L via NC, no date observed on the NC tubing or humidification water bottle. On 9/30/24 at 9:15 a.m., Resident 26 was observed lying in bed with oxygen in use. There was no date observed on the NC or humidification water bottle. On 10/1/24 at 9:49 a.m., Resident 26 was observed lying in bed with oxygen in place at 4 L via NC. There was no date observed on the NC or humidification water bottle. On 9/27/24 12:51 p.m., Resident 26's clinical record was reviewed. The diagnoses included, but not limited to, Chronic Obstructive Pulmonary Disease (COPD), Type 2 diabetes mellitus, and dementia. The quarterly Minimum Data Set (MDS) assessment, dated 7/5/24, indicated Resident 26 received oxygen therapy. The care plan, revised on 10/30/23, indicated Resident 26 had oxygen therapy related to respiratory illness. The care plan indicated to change O2 nebulizer, tubing, and humidifier weekly.		oxygen supplies. The corrective action taken for those residents found to have been affected by the deficient practice is: All residents who utilize oxygen have the potential to be affected by this deficient practice, thus the following corrective actions have been taken; an audit was completed to ensure all oxygen supplies in use were properly dated, (See Attachment C). The measures that have been put into place to ensure that the deficient practice does not recur is: As a means of ongoing compliance education was provided to all staff members involved in the handling, replacement and monitoring of oxygen tubing regarding proper procedures for labeling and dating oxygen supplies, (See Attachment D). New labeling tags were implemented to be used with all oxygen supplies upon opening and use. Visual reminders have also 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 dating compliance of oxygen supplies weekly times 4 weeks; then monthly times 3 months; then	

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	A physician's order, dated 4/15/24, indicated titrate oxygen to keep saturations greater than 92% on 2-5L per NC every shift. A physician's order, dated 9/6/24, indicated O2 tubing and humidified water change every week, night shift every Friday for oxygen usage. During an interview on 10/1/24 at 10:20 a.m., the Director of Nursing (DON) indicated Resident 26 had current order for oxygen therapy. The DON indicated that they changed the tubing and humidification bottle each week. The DON indicated the date should be written on the tubing and bottle. The DON indicated there was no date noted on nasal cannula tubing and humidification water bottle. On 10/1/24 at 2:30 p.m., the Assistant Director of Nursing (ADON) provided the facility policy, "Oxygen Administration," dated 1/8/24, she indicated it was a policy currently being used. A review of the policy indicated, "...5. Staff shall perform hand hygiene and don gloves when administering oxygen...Other infection control measures include:...b. change oxygen tubing and mask/cannula weekly...c. change humidification bottle every 72 hours or per facility policy, or as recommended by manufacturer..." 3.1-47(a)(6)		quarterly until compliance is maintained for 2 consecutive quarters. The results of the audits will be reviewed during monthly Quality Assurance/Performance Improvement meetings with the plan of action adjusted accordingly, as warranted, (See Attachment E). The above corrective actions will be completed on or before October 25, 2024.	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation, interview, and record review, the facility failed to ensure sit to stand lift foot platforms were clean for 4 of 4 sit to stand lifts observed.	F 0921	F921 The corrective action taken for those residents found to have been affected by the deficient	10/25/2024

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	Findings include: 1. On the following dates and times, a non-mechanized sit to stand lift was observed in the hallway outside of Room 504 with the foot platform containing food crumbs and debris: - On 9/27/24 at 10:10 a.m. - On 9/30/24 at 1:20 p.m. - On 10/1/24 at 11:45 a.m. 2. On the following dates and times, a non-mechanized sit to stand lift was observed in the hallway outside of Room 612 with the foot platform containing food crumbs and debris: - On 9/27/24 at 10:20 a.m. - On 9/30/24 at 1:30 p.m. - On 10/1/24 at 11:55 a.m. 3. On the following dates and times, a mechanized sit to stand lift was observed in the hallway outside of Room 610 with the foot platform containing food crumbs and debris: - On 9/27/24 at 10:25 a.m. - On 9/30/24 at 1:35 p.m. - On 10/1/24 at 11:58 a.m. 4. On the following dates and times, a non-mechanized sit to stand lift was observed in the hallway next to the Unit 500 soiled utility room with the foot platform containing food crumbs and debris: - On 9/27/24 at 10:30 a.m. - On 9/30/24 at 1:40 p.m. - On 10/1/24 at 12:02 .p.m..		practice is: No residents were affected by this deficient practice. The identified sit-to-stand lifts were immediately cleaned. The corrective action taken for those residents who have the potential to be affected by the deficient practice: All residents who utilize a sit-to-stand lift have the potential to be affected by this deficient practice, thus the following corrective actions have been taken; an inspection of all sit-to-stand lifts was completed to ensure the equipment is free of debris and soilage, (See Attachment F). The measures that have been put into place to ensure that the deficient practice does not recur is: As a means of ongoing compliance education was provided to all direct care staff involved in the use of sit-to-stand lifts regarding proper cleaning procedures for equipment, (See Attachment D). A cleaning schedule will be implemented to ensure ongoing cleanliness. 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 monitor to ensure cleanliness of sit-to-stand lifts weekly x 4 weeks, then monthly x 3 months, then quarterly until compliance is maintained for 2 consecutive quarters. The results of the audits	

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	During an interview on 10/1/24 at 3:00 p.m., the Administrator indicated the foot platforms of the sit to stand lifts were in need of cleaning before resident use. 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)		will be reviewed during monthly Quality Assurance/Performance Improvement meetings with the plan of action adjusted accordingly, as warranted, (See Attachment G). The above corrective actions will be completed on or before October 25, 2024.	