STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155524	A. BUILDING -- B. WING	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTH CENTER AT GLENBURN HOME	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/17/24 Facility Number: 000230 Provider Number: 155524 AIM Number: 100275000 At this Emergency Preparedness survey, Health Center at Glenburn Home was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 149 certified beds and had a census of 96 at the time of this visit. Quality Review completed on 10/21/24	E 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	
K 0000 Bldg. 01				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jean Johanningsmeier	Administrator	11/01/2024

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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	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/17/24 Facility Number: 000230 Provider Number: 155524 AIM Number: 100275000 At this Life Safety Code Survey, Health Center at Glenburn Home was found in substantial compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and resident sleeping rooms. The facility has a capacity of 149 and had a census of 96 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except for an attached structure used as a maintenance shop and a storage room separated from the facility by a two hour fire wall, as well as four detached storage sheds. Quality Review completed on 10/21/24	K 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	
K 0930 SS=A	NFPA 101 Gas Equipment - Liguid Oxygen Equipment			

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Bldg. 01	Based on observation and interview, the facility failed to protect 1 of 91 resident rooms from the use of liquid oxygen cylinders stored in a patient bed location or patient care room. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.7.4 states the maximum total quantity of liquid oxygen permitted in storage and in use in a patient bed location or patient care room shall be 120 L (31.6 gallons), provided that the patient bed location or patient care room, or both, are separated from the remainder of the facility by fire barriers and horizontal assemblies having a minimum fire resistance rating of 1 hour in accordance with the adopted building code. Per Centers for Medicare & Medicaid Services (CMS), this practice is deficient according to NFPA 99, 2012 Edition, Section 11.7.4. LSC 7.2.4.3.10 requires all fire door assemblies in horizontal exits to be self-closing or automatic closing. This deficient practice could affect at least 2 residents and staff. Findings include: Based on observation during a tour of the facility with the Maintenance Supervisor and Environmental Services Director on 10/17/24 between 12:25 p.m. and 2:25 p.m., an upright liquid oxygen stationary container on wheels was discovered in resident room 12 that was not separated from the remainder of the facility by fire barriers and horizontal assemblies having a minimum fire resistance rating of 1 hour. Based on interview at the time of each observation, the Maintenance Supervisor agreed there was a liquid oxygen container in the aforementioned resident sleeping room within the patient care area and the room was not at a fire resistance rating of 1 hour.	K 0930	Corrective Action Taken for Storage of Liquid Oxygen on the Identified Resident is: Upon identification of the liquid oxygen being used in a resident's room, steps were taken to remove the liquid oxygen tank from the room and transferred to the facility's designated storage area. The residents were assessed for any potential impact due to the presence of liquid oxygen in their room, with no adverse effects identified. The identified resident, along with their representative, were informed and educated on the safety and importance of proper oxygen storage for their safety. 2. Identification of Other Residents Potentially Affected: A facility-wide inspection was conducted to identify any additional residents who may have liquid oxygen stored in their rooms. All resident rooms, storage closets, and other areas were inspected for compliance with oxygen storage requirements. No additional instances of liquid oxygen storage in residents'	11/15/2024

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	This finding was reviewed with the CEO, Maintenance Supervisor and Environmental Service Director at the exit conference.		rooms were found. 3. Systemic Changes to Prevent Recurrence: Policies and procedures regarding the storage and handling of oxygen have been reviewed and updated to ensure clarity on storage location and proper handling. Staff have been re-educated on oxygen storage policies, with emphasis on the safety risks associated with liquid oxygen in resident areas. A visual checklist for oxygen storage will be added to the facility's daily safety rounds to ensure ongoing compliance. New admission with re-admission processes will include checks for oxygen storage requirements, with specific verification that liquid oxygen, if needed, is stored in designated areas. 4. Monitoring of Corrective Actions: The DON or designee will conduct audits of oxygen storage for weekly x 4 weeks, then monthly x 3 months, then quarterly until compliance is maintained for 2 consecutive quarters. The results of the audit will be reviewed during monthly	

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			Quality Assurance/Performance Improvement meetings with the plan of action adjusted accordingly, as warranted. 5. Completion Date: November 15, 2024	