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	11/21/2019

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 State Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/21/19 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 130 at the time of this visit. Quality Review completed on 12/03/19	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/21/19 Facility Number: 000230 Provider Number: 155524 AIM Number: 100275000 At this Life Safety Code survey, Health Center At	K 0000	December 12, 2019 Brenda Buroker Long Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 RE: Health Center at Glenburn Home	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Glenburn Home was found not in 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 in the 400 north hall, 500 north hall, 600 hall, and 700 hall, and 700 rehabilitation suite rooms, plus battery operated smoke detectors in the 300 south hall, 400 south hall, 500 south hall and all Special Care Unit resident sleeping rooms, including the 100 and 200 halls. The facility has a capacity of 149 and had a census of 130 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 and two P.O.D.S. trailers used for facility storage. Quality Review completed on 12/03/19		Life Safety Code with Emergency Preparedness Survey Survey Event ID S5EI21 Dear Ms. Buroker; On November 21, 2019 a Life Safety Code with Emergency Preparedness Survey was conducted at our facility. By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective December 18, 2019 to the State findings of the Life Safety Code with Emergency Preparedness Survey conducted on November 21, 2019. We respectfully request a desk review and will provide supportive documentation to validate our compliance. Please feel free to contact the facility if any additional information is needed. Respectfully submitted,	

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			Jean Johanningsmeier, HFA Administrator Health Center at Glenburn Home	
K 0321 SS=D Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			

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	Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 laundry room, a hazardous area containing fuel fired equipment of over 50 square feet in size, was provided with self-closing devices which would cause the door to automatically close and latch into the door frame or provide a smoke resistant partition. This deficient practice could affect 18 residents, as well as staff and visitors near the laundry room. Findings include: Based on observations on 11/21/19 during a tour of the facility at 12:20 p.m. with the Maintenance Supervisor, the south Laundry room door failed to self-close and latch into the door frames on multiple attempts. This area measured well over fifty square feet and contained fuel fired equipment in the form of gas dryers, as well as numerous clothes, towels, bed sheets, and linens. The south Laundry room door not fully closing and latching into the door frame was verified by the Maintenance Supervisor at the time of observation. Furthermore, the Maintenance Supervisor called to have one of his assistants work on the door as the survey continued. By the time the survey was completed, the south Laundry room door had been repaired and both closed and latched correctly. 3.1-19(b)	K 0321	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation of compliance effective December 18, 2019 to the state findings of the Life Safety Code with Emergency Preparedness Survey conducted on November 21, 2019. K 321 The corrective action taken for those residents found to be affected by the deficient practice is that the corridor door to the laundry room was immediately adjusted and now automatically closes into the door frame providing a smoke resistant partition for the eighteen residents in the immediate area as well as any employees and visitors in the immediate area. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* a housewide audit has been conducted throughout the entire facility. All self-closing devices are functioning properly allowing	12/18/2019

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			them to close automatically and latch into the door frames. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service was provided for all environmental service staff to ensure their understanding of the requirement related to self-closing door latches and their responsibility to check these doors as part of the facility's preventative maintenance program. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a quality assurance tool has been developed and implemented to monitor the proper functioning of self-closing door latches to ensure that they close properly and latch firmly into the door frames. This tool will be completed by the Maintenance Supervisor and/or his designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 2 portable fire extinguishers in the kitchen were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 1-6.3 states Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of a fire. Preferable they shall be located along normal paths of travel, including exits from areas. This deficient practice would affect all staff only in the kitchen and service hall areas. Findings include: Based on observations on 11/21/19 during a tour of the facility at 12:30 p.m. with the Maintenance Supervisor, the K class portable fire extinguisher located in the Kitchen was obstructed by a dish cart and tray return rack. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the fire extinguisher located in the Kitchen was obstructed, and not readily accessible. He further stated that he has talked with the Kitchen staff about this issue in the past. 3.1-19(b)	K 0355	K 355 The corrective action taken for those residents found to be affected by the deficient practice is that the dish cart and tray return rack has been relocated and the K class fire extinguisher in the kitchen is no longer obstructed and is clearly accessible for use. This deficient practice has the potential to affect all residents, staff and visitors in the immediate area. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* a house wide audit has been completed on all fire extinguishers in the facility. All fire extinguishers are clearly accessible and have nothing obstructing their quick access. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all dietary staff to	12/18/2019

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			ensure their understanding that fire extinguishers must be unobstructed for quick access. Nothing can be placed in the immediate area of the fire extinguishers. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a quality assurance tool has been developed and implemented to monitor the locations of fire extinguishers to ensure that the area near the fire extinguishers are not obstructed and allow immediate access to the fire extinguishers. This tool will be completed by the Maintenance Supervisor and/or his designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals			

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	defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review and interview, the facility failed to ensure 300 of 415 nonhospital-grade electrical receptacles at resident room locations were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 gram (4 ounces). This deficient practice could affect all residents.	K 0914	K 914 The corrective action taken for those residents found to be affected by the deficient practice is that the maintenance department has now completed annual testing of all nonhospital-grade electrical receptacles in each resident room locations. The testing of these receptacles is documented in the preventative maintenance binder. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that the maintenance department has now completed annual testing of all nonhospital-grade electrical receptacles in each resident room	12/18/2019

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	Findings include: Based on observations on 11/21/19 during record review at 10:54 a.m. with the Maintenance Supervisor, there was an incomplete receptacle retention testing document available for review. The facility had only completed receptacle retention testing on 23 of the 83 resident rooms within the facility. Based on observations made during a tour of the facility, the facility's 83 resident rooms had roughly 5 electrical receptacles in each room, and they were not hospital grade outlets. Based on interview at the time of the observations, the Maintenance Director indicated the electrical receptacles in the resident rooms were not hospital-grade and also indicated there was only incomplete documentation of annual testing per the NFPA 99, Receptacle Testing requirements available for review. 3.1-19(b)		locations. The testing of these receptacles is documented in the preventative maintenance binder. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all maintenance staff on the annual testing and documentation of the findings on all nonhospital-grade electrical receptacles at resident room locations. The staff was advised of their responsibility to ensure that all nonhospital-grade electrical receptacles are to be tested at least annually and the findings recorded in the preventative maintenance binder. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a quality assurance tool has been developed and implemented to ensure there is documentation to support that nonhospital-grade electrical receptacles in resident room locations has been tested at least annually as required by life safety code regulations. This tool will be completed by the Maintenance Supervisor and/or his designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality	

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			Assurance meetings to determine if any additional action is warranted.	
K 0000 Bldg. 03	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/21/19 Facility Number: 000230 Provider Number: 155524 AIM Number: 100275000 At this Life Safety Code survey, Health Center At Glenburn Home was found not in 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. The addition of Faith Hallway that was opened in 2019 was found to be of Type V (111) construction, was fully sprinklered, and was surveyed using the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This one story addition known as Faith Hall was determined to be of Type V (111) 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	K 0000		

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	resident sleeping rooms. The facility has a capacity of 149 and had a census of 130 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 and two P.O.D.S. trailers used for facility storage. Quality Review completed on 12/03/19			