	T OF REFIGENCIES		(376) 3 -	III MIDT P C :	NAME OF TAXABLE PROPERTY.		B NO. 0936-039	
		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON		ONSTRUCTION	ľ í	(3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING			COMPLETED		
		155524	B. WING			10/13/2022		
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	SUMMARY	STATEMENT OF DEFICIENCIE	ID				(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	•			TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE	
E 0000	REGULATORT OR	LISC IDENTIFTING INFORMATION		IAU			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: 10/13/22 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 97 at the time of this visit. Quality Review completed on 10/17/22		E 00	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. Due to the low scope and severity of the survey findings, please find the 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 paper compliance. Should additional information be necessary to confirm said compliance, please feel free to contact me. Respectfully submitted, Jean Johanningsmeier, HFA Administrator Health Center of Glenburn Home		on eared the e ding he irm / ting		
K 0000								
N 0000								
Bldg. 01	A Life Safety Code Recertification and State		K 0	000	Submission of this plan of			

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

(X6) DATE

TITLE

Jean Johanningsmeier RN, HFA 11/01/2022

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
		155524	B. WING			10/13/2022	
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	2			GLENBURN ROAD		
HEALTH CENTER AT GLENBURN HOME							
HEALIH	CENTER AT GLEN	NBURN HOME		LINTON	N, IN 47441		
(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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Licensure Survey w	vas conducted by the Indiana			correction does not constitute		
	Department of Heal	Ith in accordance with 42 CFR			admission or agreement by th	е	
	483.90(a).				provider of the truth of facts		
					alleged or correction set forth	on	
	Survey Date: 10/13	3/22			the Statement of Deficiencies.		
	-				The Plan of Correction is prepared		
	Facility Number: 0	000230			and submitted because of the		
	Provider Number:				requirement under State and		
	AIM Number: 100	275000			Federal law.		
					Please accept this Plan of		
	At this Life Safety	Code Survey, Health Center at			Correction as our credible		
		is found not in compliance with			allegation of compliance. Due	e to	
	Requirements for P				the low scope and severity of		
	Medicare/Medicaid	, 42 CFR Subpart 483.90(a),			survey findings, please find th		
		re and the 2012 edition of the			sufficient documentation provi		
	National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.				evidence of compliance with the	-	
					Plan of Correction. The		
					documentation serves to confi	rm	
					the Facility's allegation of		
	This one story facil	ity was determined to be of			compliance. Thus, the Facility	/	
	Type V (000) const	ruction and was fully			respectfully requests the gran		
	sprinklered. The fac	cility has a fire alarm system			of paper compliance. Should	J	
	with hard wired sm	oke detectors in the corridors,			additional information be		
	spaces open to the o	corridors, and resident			necessary to confirm said		
	sleeping rooms. The	e facility has a capacity of 149			compliance, please feel free to)	
	and had a census of	97 at the time of this survey.			contact me.		
	,						
	All areas where resi	idents have customary access			Respectfully submitted,		
	were sprinklered an	d all areas providing facility			Jean Johanningsmeier, HFA		
	services were sprinl	klered, except for an attached			Administrator		
	structure used as a 1	maintenance shop and a			Health Center of Glenburn Ho	me	
	storage room separa	ated from the facility by a two					
	hour fire wall, as well as four detached storage sheds.						
	Quality Review cor	mpleted on 10/17/22					
K 0226	NFPA 101						
SS=E	Horizontal Exits						
Bldg. 01	Horizontal Exits						
					1		l

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Event ID:

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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 01 B. WING 10/13/2022 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 (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5. 19.2.2.5 Based on observation and interview, the facility K 0226 10/25/2022 K226 requires horizontal exit failed to ensure 1 of 6 horizontal exit fire door sets fire door sets be arranged to were arranged to automatically close and latch. automatically close and latch. LSC section 7.2.4.3.10 requires all fire door 1. The corrective action taken for assemblies in horizontal exits shall be self-closing those residents found to have or automatic closing. In addition, NFPA 80, the been affected by the deficient Standard for Fire Doors and Other Opening practice is: No residents were Protectives, section 6.1.4.2.1 states self-closing affected by this alleged doors shall swing easily and freely and shall be deficient practice. The door equipped with a closing device to cause the door set on the 600 hall near to close and latch each time it is opened. This resident room 602 has been deficient could affect 25 residents and staff in 2 adjusted and is functioning smoke compartments when occupied. properly, (See Attachment A) Findings include: Based on observation with the Maintenance 2. The corrective action taken Director during a tour of the facility on 10/13/22 at for the other residents that have 12:50 p.m., the 1 ½ hour rated fire door set to the the potential to be affected by 600 Wing by resident room 602 was used as a the same deficient practice is horizontal exit and as a smoke barrier. When that: All residents have the tested, the doors failed to latch into the frame due potential to be affected by the to the doors getting hung up on the coordinator. alleged deficient practice, thus Based on interview at the time of observation, the the following corrective actions Maintenance Director stated the fire door set were have been taken; all fire door not latching into the frame and would need sets were assessed to ensure adjustment. proper closure, (See Attachment B). This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b) 3. The measures that have been put into place to ensure that the

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR		OMB NO. 0938-039				
AND PLAN OF CORRECTION ID		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155524	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/13/2022	
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	(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	
				deficient practice does not re is: As a means to ensure ongoing compliance, facility maintenance staff were educated on ensuring proper function off the fire doors as part of the preventative maintenance program, (See Attachment C).	r	
				4. The corrective action taken monitor to ensure the deficie practice will not recur is: Profunction of the fire doors will be assessed monthly ongoin as part of the preventative maintenance program. The PM logs will be reviewed for compliance as part of the facility Quality Assurance Program monthly for 3 month then quarterly until complian is maintained for two consecutive quarters, (See Attachment D). The plan of action will be adjusted accordingly, as warranted.	ent oper l gg	
				5.The above corrective actio will be completed on or befor October 25, 2022.	·	

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NFPA 101

Electrical Systems - Essential Electric Syste

K 0918

SS=F

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155524			ILDING	nstruction <u>01</u>	(X3) DATE : COMPL 10/13/	ETED	
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	(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)	ΓE	(X5) COMPLETION DATE
Bldg. 01	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro- annually confirm the safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under to year in 20-40 day once every 36 mo Scheduled test un a complete simula automatic or manu- loads, and are cor personnel. Mainte energy power sou accordance with N circuit breakers ar program for period components is est manufacturer requi of maintenance ar and readily availal and circuits are manufacturer requi of maintenance ar and separate from Minimizing the pos- emergency power consideration for r 6.4.4, 6.5.4, 6.6.4 NFPA 111, 700.10	s - Essential Electric noe and Testing other alternate power lated equipment is capable on within 10 seconds. If the in is not met during the possess shall be provided to his capability for the life branches. Maintenance generator and transfer formed in accordance with a cinspected weekly, and 30 minutes 12 times a intervals, and exercised on this for 4 continuous hours. It der load conditions include the dold start and usal transfer of all EES inducted by competent nance and testing of stored roces (Type 3 EES) are in IFPA 111. Main and feeder the inspected annually, and a dically exercising the stablished according to the stablished acc					
	facility failed to ens	review and interview, the sure documentation for 1 of 1 ors included a transfer time to source on the monthly load	K 09) 18	K918 requires documentation of emergency generators include a transfer time to alternate power source as we		10/25/2022

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Event ID:

 $TUSH21 \hspace{0.5cm} \textit{Facility ID:} \hspace{0.5cm} 000230$

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 10/13/2022 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 DEFICIENCY) DATE tests during the past 12 months to ensure the as documentation of a 5-minute alternate power supply was capable of supplying cool down period after a load service within 10 seconds. Chapter 6.4.4.1.1.1 of 2012 NFPA 99 requires the generator set or other 1. The corrective action taken for alternate power source and associated equipment, those residents found to have including all appurtenance parts, shall be so been affected by the deficient maintained as to be capable of supplying service practice is: No residents were within the shortest time practicable and within the affected by this alleged 10 second interval. This deficient practice could deficient practice. The affect all residents, as well as staff and visitors in generator has been tested the facility. under load with the transfer time and cool down time Findings include: recorded as required, (See Attachment E). Based on record review on 10/13/22 from 10:24 a.m. to 12:10 p.m. with the Maintenance Director present, the generator log form documented the generator was tested monthly for at least 30 2. The corrective action taken minutes under load, however, the generator form for the other residents that have lacked documentation of a transfer time from the potential to be affected by normal power to emergency power during the past the same deficient practice is 12 months. At the time of record review, the that: All residents have the Maintenance Director agreed that there was no potential to be affected by the transfer time listed on the monthly generator load alleged deficient practice, thus test documentation during the past 12 months. the following corrective actions have been taken; the generator This finding was reviewed with the Maintenance was tested under load with the Director at the exit conference. transfer time and cool down time recorded as required, 2. Based on record review and interview, the (See Attachment E). facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard 3. The measures that have been

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for Emergency and Standby Powers Systems,

Chapter 8. NFPA 110, 6.2.10 Time Delay on Engine

Shutdown requires that a minimum time delay of 5

minutes shall be provided for unloaded running of

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put into place to ensure that the

deficient practice does not recur

is: As a means to ensure

ongoing compliance, facility

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CENTERS FOR MEDICARE & MEDICAID 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 01 B. WING 10/13/2022 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 (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE the Emergency Power Supply (EPS) prior to maintenance staff were shutdown. This delay provides additional engine educated on ensuring proper cool down. This time delay shall not be required documentation regarding the on small (15 kW or less) air-cooled prime movers. generator as part of the This deficient practice could affect all residents, preventative maintenance as well as staff and visitors in the facility. program, (See Attachment C). Findings include: Based on record review with the Maintenance 4. The corrective action taken to Director on 10/13/22 from 10:24 a.m. to 12:10 p..m.. monitor to ensure the deficient the generator log form documented the generator practice will not recur is: Proper was tested monthly for at least 30 minutes under documentation of the load, however, there was no documentation on generator function will be the form that showed the generator had a cool assessed monthly ongoing as down time following its load test. Based on part of the preventative interview at the time of record review, the maintenance program. The Maintenance Director stated the generator does PM logs will be reviewed for have a cool down period after running under load, compliance as part of the but agreed that a cool down time was not facility Quality Assurance documented on the monthly documentation. Program monthly for 3 months, then quarterly until compliance This finding was reviewed with the Maintenance is maintained for two Director at the exit conference. consecutive quarters, (See Attachment F). The plan of 3.1-19(b) action will be adjusted accordingly, as warranted. 5. The above corrective action will be completed on or before October 25, 2022. K 0000

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A Life Safety Code Recertification and State

Bldg. 03

Event ID:

TUSH21

K 0000

Facility ID: 000230

Submission of this plan of

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11/02/2022 PRINTED: FORM APPROVED 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 03 B. WING 10/13/2022 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 (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Licensure Survey was conducted by the Indiana correction does not constitute Department of Health in accordance with 42 CFR admission or agreement by the 483.90(a). provider of the truth of facts alleged or correction set forth on Survey Date: 10/13/22 the Statement of Deficiencies. The Plan of Correction is prepared Facility Number: 000230 and submitted because of the Provider Number: 155524 requirement under State and AIM Number: 100275000 Federal law. Please accept this Plan of At this Life Safety Code Survey, Health Center at Correction as our credible Glenburn Home was found in compliance with allegation of compliance. Due to Requirements for Participation in the low scope and severity of the Medicare/Medicaid, 42 CFR Subpart 483.90(a), survey findings, please find the Life Safety from Fire and the 2012 edition of the sufficient documentation providing National Fire Protection Association (NFPA) 101, evidence of compliance with the Life Safety Code (LSC), Chapter 18, New Health Plan of Correction. The Care Occupancies and 410 IAC 16.2. documentation serves to confirm the Facility's allegation of This one story addition known as Faith Hall, that compliance. Thus, the Facility was opened in 2019, was determined to be of Type respectfully requests the granting V (111) construction and was fully sprinklered. of paper compliance. Should The facility has a fire alarm system with hard wired additional information be smoke detectors in the corridors, spaces open to necessary to confirm said the corridors, and resident sleeping rooms. The compliance, please feel free to addition has a capacity of 12 and had a census of contact me. 12 at the time of this survey. Respectfully submitted, All areas where residents have customary access Jean Johanningsmeier, HFA were sprinklered and all areas providing facility Administrator services were sprinklered, except for an attached Health Center of Glenburn Home 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 10/17/22 K 0000

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE S	DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>04</u> COM		COMPLE	MPLETED	
		155524	B. WING	10/13/20		2022	
			 =				
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
HEALTH	CENTER AT GLEN	IBURN HOME	618 W GLENBURN ROAD LINTON, IN 47441				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID	DROWINED BY AN OF CODDECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG			DATE	
Bldg. 04							
-	A Life Safety Code	Recertification and State	K 0000	Submission of this plan of			
	-	as conducted by the Indiana		correction does not constitute			
		th in accordance with 42 CFR		admission or agreement by th			
	483.90(a).			provider of the truth of facts alleged or correction set forth on			
	()						
	Survey Date: 10/13	/22		the Statement of Deficiencies.	- I		
	J			The Plan of Correction is prep			
	Facility Number: 0	00230		and submitted because of the	1		
	Provider Number:			requirement under State and			
	AIM Number: 1002			Federal law.			
	Alivi Ivaliluci. 1002/3000			Please accept this Plan of			
	At this Life Safety Code Survey, Health Center at			Correction as our credible			
	Glenburn Home was found in compliance with			allegation of compliance. Due to			
	Requirements for Participation in			the low scope and severity of the			
	Medicare/Medicaid, 42 CFR Subpart 483.90(a),			survey findings, please find th			
	Life Safety from Fire and the 2012 edition of the			sufficient documentation provi			
	National Fire Protection Association (NFPA) 101,			evidence of compliance with the	-		
	Life Safety Code (LSC), Chapter 18, New Health			Plan of Correction. The			
	Care Occupancies and 410 IAC 16.2.			documentation serves to confi	irm		
	Care Occupancies and 410 IAC 16.2.			the Facility's allegation of			
	The 800 Wing addition was a one story fully sprinklered building determined to be of Type V			compliance. Thus, the Facility	,		
				respectfully requests the gran			
				of paper compliance. Should	ung		
	(111) construction. This portion of the facility had a fire alarm system with hard wired smoke			additional information be			
	-	idors, spaces open to the		necessary to confirm said			
		ur resident sleeping rooms.		-			
				compliance, please feel free to	J		
	The census of the 800 Wing was zero. All areas where residents have customary access			contact me.			
				Respectfully submitted,			
		d all areas providing facility		Jean Johanningsmeier, HFA			
	-			Administrator			
	services were sprinklered, except for an attached structure used as a maintenance shop and a storage room separated from the facility by a two			Health Center of Glenburn Ho	me		
				Ticalin Center of Gleribulli Ho	1116		
		ell as four detached storage					
	sheds.	in as rour detaction storage					
	sneds.						
	Quality Review con	onleted on 10/17/22					
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