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	05/25/2023

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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00406868. Complaint IN00406868 - Federal/State deficiencies related to the allegations are cited at F602. Survey date: May 25, 2023 Facility number: 000230 Provider number: 155524 AIM number: 100275000 Census Bed Type: SNF/NF: 87 Total: 87 Census Payor Type: Medicare: 10 Medicaid: 61 Other: 16 Total: 87 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 31, 2023.	F 0000	June 14, 2023 Brenda Buroker Director of Long-Term Care Long Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 RE: Health Center at Glenburn Home Survey Event ID 6GOW11 Dear Ms. Buroker; On May 25, 2023, a Complaint 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 June 14, 2023, to the State findings of the Complaint Survey conducted on May 25, 2023. We respectfully request a desk	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jean Johanningsmeier	RN, HFA	06/16/2023

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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			review to validate the facility's compliance to the findings of the Complaint Survey of May 25, 2023. Please feel free to contact the facility if any additional information is needed. Respectfully submitted, Jean Johanningsmeier, HFA Administrator Health Center at Glenburn Home	
F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Based on interview and record review, the facility failed to protect the residents right to be free from misappropriation of resident property for 1 of 3 residents reviewed. (Resident B, RN 1) Finding include: During an interview on 5/25/23 at 2:00 P.M., the DON indicated she was approached by a nurse at the end of March 2023 who was concerned with a residents muscle relaxer. Resident B was running out of the muscle relaxer too soon. The DON	F 0602	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. /p> /p>	06/14/2023

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	indicated she waited until the next delivery and took a picture of the medication. At that time, the DON noticed the medication was missing but documented as administered on the MAR (Medication Administration Record). The DON indicated RN 1 was the nurse removing the medication from the EDK (Emergency Drug Kit). The DON indicated the following morning picture of the medication indicated 7 pills were missing and Resident B was only prescribed to take one pill three times a day. She also indicated RN 1 was the only person to have the keys to the medication cart. RN 1 denied taking any medication, didn't return to the facility, and stopped responding to their phone calls. The DON indicated during the facility investigation, the DON and Administrator checked RN 1's office and found 2 empty pill packets for the muscle relaxer, dating back to December 2022 in her file cabinet. The pill packet had contained tizanidine HCl Tablet 4 mg (milligrams). On 5/25/23 at 2:15 P.M., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, anxiety, and diabetes. The Annual Minimum Data Set (MDS) assessment, dated 3/4/22, indicated Resident B was cognitively intact. The Physician's Orders included, but were not limited to: Tizanidine HCl (muscle relaxer) 4 mg, three times a day, initiated on 6/15/22. On 5/25/23 at 2:45 P.M., RN 1 was unable to be contacted for interview. On 5/25/23 at 2:06 P.M., the Administrator		*The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident B had a complete audit of the medication cart, medication administration record, Nexsys system and Narcotic record, (See Attachment A). No further discrepancies were noted. Resident B was assessed for pain in correlation to medication missing. No correlation was noted. *The corrective action taken for those residents found to have been affected by the deficient practice is* that there were no other residents affected by this alleged deficient practice. All residents have the potential to be affected by this deficient practice thus the following corrective actions have been taken; An audit of all medication carts and medication administration records has been completed to ensure that there is no “refill too soon” alert or frequent Nexsys pulls noted, (See Attachment B). *The measures that have been put into place to ensure that the deficient practice does not recur is* that a mandatory in-service and medication competency has been conducted for all licensed nurses and QMAs relating to medication management policy and medication administration. The in-service focused on the nurse’s	

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	provided the current Medication Management Policy, undated, and indicated it was the current policy in use by the facility. It indicated the policy was to promote a safe and accurate medication management system for each individual resident. This Federal tag is related to Complaint IN00406868. 3.1-28(a)		and QMA's responsibility on following facility policy relating to medication management and medication administration procedures, (See Attachment C). *The corrective action taken to monitor to ensure the deficient practice will not recur is* in relation to Quality Assurance, the DON or designee will monitor all "refill too soon" alerts and Nexsys pull reports weekly x 4, then monthly x 3, then quarterly until compliance is maintained for 2 consecutive quarters, (See Attachment D). The outcome of the reports will be provided to the IDT at the Facility's Quality Assurance/Performance Improvement monthly meetings to determine if any additional action is warranted and will be reviewed as part of the regularly scheduled Quality/ Performance Improvement meetings. The above corrective actions will be completed on or before June 14, 2023.	