DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/11/2022 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION 155524 155524	STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER HEALTH CENTER AT GLENBURN HOME SITREET ADDRESS. CITY. STATE, ZIP CODE 618 W GLENBURN ROAD LINTON, IN 47441 SUPPLIES TAG REGULATORY OR I SC IDENTIFYING INFORMATION) FOUND Bidg. 00 Bidg. 00 FOUND Submission of this plan of correction dees 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 and Federal law. Please accept this Plan of Correction sprepared and submitted because of the requirement under State and Federal law. Please accept this Plan of Correction for the survey dated March 9-10, 2022. Due to the low scope and severity of the survey findings, please find the sufficient documentation providing evidence of compliance effective April 1, 2022. Please find enclosed the Plan of Correction for the survey gated March 9-10, 2022. 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. Thus, the Facility respectfully requests the granting of paper compliance. This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 29, 2022. We consider the plan of Correction for the survey findings allegation of compliance. Should additional information be necessary to confirm the Facility's allegation of compliance, please fell free to contact me. Respectfully submitted, Jean Johanningsmeier, HFA Administrator.	AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>		COMPLETED		
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Jean Johanningsmeier, HFA Administrator		Quality review com	npleted on April 29, 2022.			contact me.			
Jean Johanningsmeier, HFA Administrator						Respectfully submitted,			
Administrator						T			
Health Center of Glenburn Home						_			
						Health Center of Glenburn Ho	me		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/SU		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 04/28/2022						
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 618 W GLENBURN ROAD LINTON, IN 47441					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION			
F 0888 SS=A Bldg. 00	§483.80(i) COVID-19 Vaccin facility must devel and procedures to fully vaccinated for purposes of this seriully vaccinated if more since they covaccination series completion of a profor COVID-19 is diadministration of a the administration multi-dose vaccination series vaccination for the administration of a the administration multi-dose vaccination facility staff, who procedures mad procedures	ation of Facility Staff ation of facility staff. The op and implement policies of ensure that all staff are or COVID-19. For ection, staff are considered it has been 2 weeks or completed a primary for COVID-19. The imary vaccination series effined here as the a single-dose vaccine, or of all required doses of a ection. gardless of clinical esident contact, the policies must apply to the following provide any care, or services for the facility services;						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KWXJ11 Facility ID: 000230

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/11/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/S		r í	UILDING	onstruction 00	(X3) DATE COMPL 04/28/	ETED		
NAME OF PROVIDER OR SUPPLIER HEALTH CENTER AT GLENBURN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 618 W GLENBURN ROAD LINTON, IN 47441					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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 APPROPRI. DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	(ii) Staff who provide facility that are outside of the facil have any direct coother staff specified this section. §483.80(i)(3) The must include, at a components: (i) A process for experimental include, at a components: (i) A process for experimental include, at a components: (i) A process for experimental include, at a component in paragraph (i)(1) those staff who have been grown vaccination requires those staff for who must be temporarize recommended by precautions and correceived, at a min COVID-19 vaccine any care, treatment facility and/or its recomponentation of intended to mitigate spread of COVID-fully vaccinated for intended to mitiga	ide support services for a performed exclusively ity setting and who do not entact with residents and ad in paragraph (i)(1) of policies and procedures minimum, the following ensuring all staff specified of this section (except for ove pending requests for, or anted, exemptions to the ements of this section, or own COVID-19 vaccination ly delayed, as the CDC, due to clinical considerations) have finum, a single-dose ending requests for a multi-dose ending providing and the country of the esidents; ensuring the additional precautions, the the transmission and 19, for all staff who are not or COVID-19; tracking and securely covID-19 vaccination pecified in paragraph (i)(1) racking and securely covID-19 vaccination who have obtained any recommended by the CDC; which staff may request an						

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING <u>00</u>			COMPLETED		
155524		B. W	ING		04/28/	2022	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				1	GLENBURN ROAD		
HEALTH CENTER AT GLENBURN HOME							
HEALIH	CENTER AT GLEN	IBURN HOWE		LINTON	I, IN 47441		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION
TAG				TAG	DEFICIENCY)		DATE
	vaccination require	ements based on an					
	applicable Federa	l law;					
	(vii) A process for	tracking and securely					
	documenting infor	mation provided by those					
	staff who have red	quested, and for whom the					
	facility has granted	d, an exemption from the					
	staff COVID-19 va	accination requirements;					
	(viii) A process for	ensuring that all					
	documentation, w	hich confirms recognized					
	clinical contraindic	cations to COVID-19					
	vaccines and which	ch supports staff requests					
	for medical exemp	otions from vaccination, has					
	been signed and o	dated by a licensed					
	practitioner, who is not the individual						
	requesting the exemption, and who is acting						
	within their respec	tive scope of practice as					
		accordance with, all					
	applicable State a	nd local laws, and for					
	further ensuring th	at such documentation					
	contains:						
	(A) All information	specifying which of the					
	authorized COVID)-19 vaccines are clinically					
	contraindicated fo	r the staff member to					
	receive and the re	cognized clinical reasons					
	for the contraindic						
	(B) A statement by	y the authenticating					
	1 ' '	mending that the staff					
	_ ·	oted from the facility's					
	· ·	ation requirements for staff					
	based on the reco						
	contraindications;	-					
	· ·	ensuring the tracking and					
	` ' '	ation of the vaccination					
	status of staff for v	whom COVID-19					
	vaccination must l	oe temporarily delayed, as					
		the CDC, due to clinical					
	I -	onsiderations, including,					
	I '	individuals with acute					
	illness secondary						
	· ·	ceived monoclonal					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BU	A. BUILDING 00 COM			COMPLETED	
		155524			04/28	04/28/2022		
				CERTE	A DODDEGG CHEVY CELLER THE THE CODE		-	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE			
				618 W GLENBURN ROAD				
HEALTH	CENTER AT GLEN	NBURN HOME		LINTON, IN 47441				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	antibodies or conv	valescent plasma for						
	COVID-19 treatm	ent; and						
	(x) Contingency p	lans for staff who are not						
	fully vaccinated for	or COVID-19.						
	Effective 60 Days	After Publication:						
	§483.80(i)(3)(ii) A	A process for ensuring that						
	all staff specified i	n paragraph (i)(1) of this						
		accinated for COVID-19,						
	except for those s	taff who have been granted						
		vaccination requirements						
	· ·	those staff for whom						
	COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due							
	to clinical precautions and considerations;							
			F 0	888			05/06/2022	
					F888 requires the facility to			
	Based on interview and record review, the				develop and implement police			
	1	low the policy for COVID-19			and procedures to ensure th			
		or medical exemptions, the			all staff are fully vaccinated	for		
	-	o specify which vaccine was			COVID-19.			
		the clinically recognized			1. The corrective action			
		r 2 of 2 staff medical			taken for those residents for			
	_	ed. (Employee 1, Employee			to have been affected by the			
	2)				deficient practice is: No			
					residents were affected by this	8		
	Findings include:				alleged deficient practice.			
	1 0 - 4/29/22 - 1 :	15 E			2 The comment of the section			
		15 p.m., Employee 1's			2. The corrective action taken for the other residents			
	COVID-19 medical exemption was reviewed. The medical exemption signed 12/2/21,							
	_	_			that have the potential to be			
	indicated Employee 1 was undergoing treatment				affected by the same deficie practice is that: All residents			
	and medication therapy following a new medical diagnosis, it was recommended that Employee 1				have the potential to be affect			
	not receive any add				by the alleged deficient practic			
	vaccinations until f				thus the following corrective	. c ,		
	vaccinations until 1	urmer nouce.			actions have been taken; the			
	On 4/28/22 at 1:20	n m the Infection			medical exemptions for the 2			
		p.m., the infection yed the physician believed			employees in question were			
		medical diagnosis was caused			reviewed and updated, as			
	Limpioyee I s new i	neurear diagnosis was caused	ı		r reviewed and updated, as		I	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COM		COMPL	ETED		
		155524			04/28/	04/28/2022		
				CEDELE	ADDRESS OF THE STREET STREET		-	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE			
				618 W GLENBURN ROAD				
HEALTH	CENTER AT GLEN	IBURN HOME		LINTON	N, IN 47441			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWING DEAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T-	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE	
	by the first dose of	COVID-19 vaccination.			warranted. There are no othe	r		
	J				medical exemptions in the faci			
	2. On 4/28/22 at 1:3	30 p.m., Employee 2's			at this time.	,		
		exemption was reviewed.						
		tion indicated that the						
	-	of the person or medical			3. The measures that have	е		
		ed to the person are such that			been put into place to ensure			
		not considered safe or			that the deficient practice do			
	advisable related to	the diagnoses listed. The			not recur is: As a means to			
		nt, undated, indicated please			ensure ongoing compliance th	е		
	give employee med	ical exemption from			facility policy regarding vaccing	е		
	receiving COVID-1	-			exemptions was reviewed and			
					updated, as warranted.			
	On 4/28/22 at 1:45 p.m., the Administrator							
	indicated she believed the staff members medical				4. The corrective action			
	condition was a contraindication to all three				taken to monitor to ensure th	ne		
	vaccines.				deficient practice will not red	cur		
					is: A Quality Assurance tool h	as		
	On 4/28/22 at 2:16	p.m., the Administrator			been developed and impleme	nted		
	provided the curren	t "Employee COVID-19			to monitor documentation of a	II		
	Vaccination Exemp	tion" policy, undated. The			newly hired employee			
	policy included, but	t was not limited to:			vaccinations and/or exemptior	ns to		
	"Requests for medic	cal exemptions to the			ensure timely compliance, (Se	e		
	COVID-19 vaccine	s must include the following			Attachment A). This tool will be	е		
	documentation: a. a	ll information specifying			completed by the Infection Co			
	which of the author	ized COVID-19 vaccines are			Preventionist or designee wee	kly x		
	clinically contraind	icated for the employee to			4 weeks, then monthly x 3 mo	nths,		
	receive, and the rec	ognized clinical reasons for			and then quarterly for 3 quarte	ers.		
	the contraindication	ıs"			The outcomes of this tool will	be		
					reviewed at the facility's Quali	-		
	3.1-18(b)				Assurance meetings with the p			
					of action adjusted accordingly	, as		
					warranted.			
					5. The above corrective act			
					will be completed on or before			
					May 6, 2022.			
			ı					

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