PRINTED: 11/02/2022 FORM APPROVED

CENTERS FOR	CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039							
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155524		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/13/2022			
	PROVIDER OR SUPPLIE			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)	ιΤΕ	(X5) COMPLETION DATE	
E 0000 Bldg K 0000 Bldg. 01	conducted by the Ir accordance with 42 Survey Date: 10/1; Facility Number: (Provider Number: AIM Number: 100) At this Emergency Center at Glenburn compliance with En Requirements for Nearticipating Provides 483.73 The facility has a count and had a census of	3/22 000230 155524	E 00	000	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 the Statement of Deficiencies. The Plan of Correction is prepand submitted because of the requirement under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance. Due the low scope and severity of survey findings, please find the sufficient documentation provievidence of compliance with the Plan of Correction. The documentation serves to confithe Facility's allegation of compliance. Thus, the Facility respectfully requests the gran 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 Ho	on beared e to the e iding he irm		
	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 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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STATEMENT OF DEFICIENCIES 2		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLETED	
155524		B. WING 10/13/2022					
				CTREET	ADDRESS SITU STATE ZIR SOD		
NAME OF F	PROVIDER OR SUPPLIER	t .			ADDRESS, CITY, STATE, ZIP COD		
	OFNITED AT OLEA	IDLIDALLIOME			GLENBURN ROAD		
HEALTH CENTER AT GLENBURN HOME			LINTOR	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	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	VIE.	DATE
	Licensure Survey w	vas conducted by the Indiana			correction does not constitute		
	Department of Heal	th 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 prep		
	Facility Number: 0	00230			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		
		s found not in compliance with			allegation of compliance. Due	e to	
	Requirements for P				the low scope and severity of		
	_	, 42 CFR Subpart 483.90(a),			survey findings, please find th		
		re and the 2012 edition of the			sufficient documentation provi		
	· ·	etion Association (NFPA) 101,			evidence of compliance with t	-	
		LSC), Chapter 19, Existing			Plan of Correction. The	ii C	
		ancies and 410 IAC 16.2.			documentation serves to conf	irm	
	Trouver cure courp				the Facility's allegation of		
	This one story facil	ity was determined to be of			compliance. Thus, the Facility	,	
	1	ruction and was fully			respectfully requests the gran		
		cility has a fire alarm system			of paper compliance. Should	ung	
	_	oke detectors in the corridors,			additional information be		
		corridors, and resident			necessary to confirm said		
		e facility has a capacity of 149			compliance, please feel free to	<u> </u>	
		97 at the time of this survey.			contact me.	J	
	una naa a consus or	y, at the time of this survey.			contact me.		
	All areas where resi	idents have customary access			Respectfully submitted,		
		d all areas providing facility			Jean Johanningsmeier, HFA		
	_	klered, except for an attached			Administrator		
	_	naintenance shop and a			Health Center of Glenburn Ho	me	
		ated from the facility by a two			Treatin Genter of Glenburn ne	1110	
		ell as four detached storage					
	sheds.	rour armoned storage					
	51104651						
	Quality Review cor	npleted on 10/17/22					
K 0226	NFPA 101						
SS=E	Horizontal Exits						
Bldg. 01	Horizontal Exits						

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
155524		B. WING 10/13/2022					
		1		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			GLENBURN ROAD		
HFAI TH	CENTER AT GLEN	JBURN HOME			N, IN 47441		
	T. T		1		-,		,
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, and the second	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	· ·	used, are in accordance					
		provisions of 18.2.2.5.1					
	_	7, or 19.2.2.5.1 through					
	19.2.2.5.4.						
	18.2.2.5, 19.2.2.5	on and interview, the facility	K ₀	226	K226 requires harizontal avit		10/25/2022
		f 6 horizontal exit fire door sets	~ 0	440	K226 requires horizontal exit fire door sets be arranged to		10/25/2022
		tomatically close and latch.			automatically close and latel		
	_	5.10 requires all fire door			1.The corrective action taken		
		ontal exits shall be self-closing			those residents found to have		
		g. In addition, NFPA 80, the			been affected by the deficier		
		oors and Other Opening			practice is: No residents we		
		6.1.4.2.1 states self-closing			affected by this alleged		
		asily and freely and shall be			deficient practice. The door set on the 600 hall near resident room 602 has been		
	equipped with a clo	sing device to cause the door					
	to close and latch ea	ach time it is opened. This					
		ct 25 residents and staff in 2			adjusted and is functioning		
	smoke compartmen	ts when occupied.			properly, (See Attachment A)	
	Findings include:						
	Based on observation	on with the Maintenance			2. The corrective action take	en	
		our of the facility on 10/13/22 at			for the other residents that h		
	_	hour rated fire door set to the			the potential to be affected b		
	_	ent room 602 was used as a			the same deficient practice i	_	
		as a smoke barrier. When			that: All residents have the		
	tested, the doors fai	led to latch into the frame due			potential to be affected by th	е	
	to the doors getting	hung up on the coordinator.			alleged deficient practice, th		
		at the time of observation, the			the following corrective action		
	Maintenance Direct	tor stated the fire door set were			have been taken; all fire doo		
	not latching into the frame and would need				sets were assessed to ensur	e	
	adjustment.				proper closure, (See		
					Attachment B).		
		viewed with the Maintenance					
	Director during the	exit conference.					
	3.1-19(b)						
					3.The measures that have b	een	
					put into place to ensure that	the	

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

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		, and the second se		ULTIPLE CC UILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED			
			B. WING 10/13/20.						
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		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	(X5) COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		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 take 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 mont then quarterly until compliant is maintained for two consecutive quarters, (See Attachment D). The plan of action will be adjusted accordingly, as warranted.	ent oper I ng hs,			
					5.The above corrective actic will be completed on or befo October 25, 2022.				
K 0918 SS=F	NFPA 101 Electrical Systems	s - Essential Electric Syste							

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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 <u>01</u>		COMPLETED	
		155524	B. W	ING		10/13	/2022
		<u>I</u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
NAME OF P	PROVIDER OR SUPPLIEF	R			GLENBURN ROAD		
HEALTH	CENTER AT GLEN	NBURN HOME			N, IN 47441		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 01	1	s - Essential Electric					
	System Maintena	-					
	_	other alternate power					
		iated equipment is capable					
		ce within 10 seconds. If the					
		on is not met during the					
		ocess shall be provided to					
	1	his capability for the life					
	· ·	branches. Maintenance					
	_	generator and transfer					
	switches are perfo NFPA 110.	ormed in accordance with					
		e inspected weekly,					
		oad 30 minutes 12 times a					
		intervals, and exercised					
	1 -	onths for 4 continuous hours.					
	1	nder load conditions include					
	a complete simula						
	I	ual transfer of all EES					
		nducted by competent					
		enance and testing of stored					
	1 ·	ırces (Type 3 EES) are in					
	1	NFPA 111. Main and feeder					
	circuit breakers ar	re inspected annually, and a					
		dically exercising the					
		tablished according to					
	1	uirements. Written records					
		nd testing are maintained					
		ble. EES electrical panels					
	1	arked, readily identifiable,					
	and separate from	n normal power circuits.					
	Minimizing the po	ssibility of damage of the					
	emergency power	r source is a design					
	consideration for	new installations.					
	6.4.4, 6.5.4, 6.6.4	(NFPA 99), NFPA 110,					
	NFPA 111, 700.10	0 (NFPA 70)					
	1. Based on record	review and interview, the	K 0	918	K918 requires documentation	on	10/25/2022
	facility failed to ens	sure documentation for 1 of 1			of emergency generators		
	emergency generate	ors included a transfer time to			include a transfer time to		
	the alternate power	source on the monthly load			alternate power source as w	Æ	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	ì í	JILDING	01	COMPLETED	
		155524	B. WING 10/13/2022		2022		
		<u> </u>		CTDEET !	ADDRESS CITY STATE ZIR COD		
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD GLENBURN ROAD		
HEALTH	CENTER AT GLEN	NBURN HOME			N, IN 47441		
	CLIVILITAI GLEI	ADDITION I		LINTON	v,v 7/77!		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI.	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		at 12 months to ensure the			as documentation of a 5-mir		
		oply was capable of supplying			cool down period after a loa	d	
		econds. Chapter 6.4.4.1.1.1 of			test.	_	
	-	uires the generator set or other			1.The corrective action take	-	
	-	arce and associated equipment,			those residents found to ha	_	
		tenance parts, shall be so			been affected by the deficie		
		capable of supplying service			practice is: No residents we	ere	
		time practicable and within the			affected by this alleged		
		This deficient practice could			deficient practice. The		
		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		
	Dagad or1	riovy on 10/12/22 for an 10/24			Attachment E).		
		view on 10/13/22 from 10:24					
		with the Maintenance Director					
		tor log form documented the			2. The corrective seties to the		
	-	d monthly for at least 30 , however, the generator form			2. The corrective action tak	-	
		ion of a transfer time from			for the other residents that	-	
		nergency power during the past			the potential to be affected the same deficient practice		
	_	time of record review, the			the same deficient practice that: All residents have the	13	
		tor agreed that there was no			potential to be affected by the	20	
		on the monthly generator load			alleged deficient practice, the		
		during the past 12 months.			the following corrective acti		
	tost documentation	coring the past 12 months.			have been taken; the genera		
	This finding was re	eviewed with the Maintenance			was tested under load with		
	Director at the exit				transfer time and cool down		
					time recorded as required,		
	2. Based on record	review and interview, the			(See Attachment E).		
		sure 1 of 1 emergency			\		
	-	owed a 5 minute cool down					
	_	test. Chapter 6.4.4.1.1.4(a) of					
	-	uires monthly testing of the					
	_	he emergency electrical system					
	-	with NFPA 110, the Standard			3.The measures that have b	oeen	
		Standby Powers Systems,			put into place to ensure tha	t the	
		10, 6.2.10 Time Delay on Engine			deficient practice does not		
	-	that a minimum time delay of 5			is: As a means to ensure		
	minutes shall be provided for unloaded running of				ongoing compliance, facility	,	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155524		(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION O O O O O O O O O O O O	(X3) DATE SURVEY COMPLETED 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 PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL AG REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION		
	shutdown. This dela cool down. This tim on small (15 kW or This deficient practi	rer Supply (EPS) prior to my provides additional engine he delay shall not be required less) air-cooled prime movers. lice could affect all residents, visitors in the facility.		maintenance staff were educated on ensuring prop documentation regarding t generator as part of the preventative maintenance program, (See Attachment	he		
	Director on 10/13/2 the generator log fo was tested monthly load, however, there the form that showedown time followin interview at the time Maintenance Direct have a cool down pubut agreed that a cool documented on the	riew with the Maintenance 2 from 10:24 a.m. to 12:10 pm., rm documented the generator for at least 30 minutes under e was no documentation on d the generator had a cool g its load test. Based on e of record review, the or stated the generator does eriod after running under load, ol down time was not monthly documentation. viewed with the Maintenance conference.		4. The corrective action tal monitor to ensure the defineractice will not recur is: For documentation of the generator function will be assessed monthly ongoing 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 monthen quarterly until complicis maintained for two consecutive quarters, (See Attachment F). The plan consecutive distributed accordingly, as warranted. 5. The above corrective accivility be completed on or be October 25, 2022.	cient Proper g as e or nths, ance of		
K 0000							
Bldg. 03	A Life Safety Code	Recertification and State	K 0000	Submission of this plan of			

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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 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) PR		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		LE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	UILDIN	NG	04	COMPLETED	
155524		155524	B. WING				10/13/2022	
				O.T.		DDDEGG CHTV CT TT TD CCT		
NAME OF P	ROVIDER OR SUPPLIEF	8				ADDRESS, CITY, STATE, ZIP COD		
		IDLIDALLIOME				GLENBURN ROAD		
HEALTH	CENTER AT GLEN	NDURN HUWE		LIN	N I ON	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		PREF	IX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TA	G	DEFICIENCY)		DATE
Bldg. 04								
	A Life Safety Code	Recertification and State	K 0	000		Submission of this plan of		
	Licensure Survey w	as 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 prep	ared	
	Facility Number: 0					and submitted because of the		
	Provider Number:	155524				requirement under State and		
	AIM Number: 100	275000				Federal law.		
						Please accept this Plan of		
	•	Code Survey, Health Center at				Correction as our credible		
		s found in compliance with				allegation of compliance. Due to		
	Requirements for P	-		the low scope and severity of the				
		, 42 CFR Subpart 483.90(a),				survey findings, please find th		
	-	re and the 2012 edition of the				sufficient documentation provi	-	
		ction Association (NFPA) 101,				evidence of compliance with t	he	
		LSC), Chapter 18, New Health				Plan of Correction. The		
	Care Occupancies a	and 410 IAC 16.2.				documentation serves to confi	irm	
						the Facility's allegation of		
	_	tion was a one story fully				compliance. Thus, the Facility		
		g determined to be of Type V				respectfully requests the gran	ting	
		This portion of the facility had				of paper compliance. Should		
	-	with hard wired smoke				additional information be		
		ridors, spaces open to the				necessary to confirm said		
		our resident sleeping rooms.				compliance, please feel free to)	
	The census of the 8	00 Wing was zero.				contact me.		
		idents have customary access				Respectfully submitted,		
	-	d all areas providing facility				Jean Johanningsmeier, HFA		
	-	klered, except for an attached				Administrator		
		maintenance shop and a				Health Center of Glenburn Ho	me	
		ated from the facility by a two						
		ell as four detached storage						
	sheds.							
	O III P	1 . 1 . 10/17/00						
	Quality Review cor	mpleted on 10/17/22						

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