| 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 | 10/13/2022 |

| 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<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 10/13/22<br><br>Facility Number: 000230<br>Provider Number: 155524<br>AIM Number: 100275000<br><br>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<br><br>The facility has a capacity of 149 certified beds and had a census of 97 at the time of this visit.<br><br>Quality Review completed on 10/17/22 | E 0000 | 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.<br><br>Respectfully submitted,<br>Jean Johanningsmeier, HFA<br>Administrator<br>Health Center of Glenburn Home | |
| K 0000<br><br>Bldg. 01 | A Life Safety Code Recertification and State | K 0000 | Submission of this plan of | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155524 | A. BUILDING 01<br>B. WING | 10/13/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HEALTH CENTER AT GLENBURN HOME | 618 W GLENBURN ROAD<br>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 |
|---|---|---|---|---|
| | Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 10/13/22<br><br>Facility Number: 000230<br>Provider Number: 155524<br>AIM Number: 100275000<br><br>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.<br><br>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. The facility has a capacity of 149 and had a census of 97 at the time of this survey.<br><br>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.<br><br>Quality Review completed on 10/17/22 | | 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.<br>The Plan of Correction is prepared and submitted because of the requirement under State and Federal law.<br>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.<br><br>Respectfully submitted,<br>Jean Johanningsmeier, HFA<br>Administrator<br>Health Center of Glenburn Home | |
| K 0226<br>SS=E<br>Bldg. 01 | NFPA 101<br>Horizontal Exits<br>Horizontal Exits | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155524 | A. BUILDING 01<br>B. WING | 10/13/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HEALTH CENTER AT GLENBURN HOME | 618 W GLENBURN ROAD<br>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 |
|---|---|---|---|---|
| | 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.<br>18.2.2.5, 19.2.2.5<br>Based on observation and interview, the facility failed to ensure 1 of 6 horizontal exit fire door sets were arranged to automatically close and latch. LSC section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic closing. In addition, NFPA 80, the Standard for Fire Doors and Other Opening Protectives, section 6.1.4.2.1 states self-closing doors shall swing easily and freely and shall be equipped with a closing device to cause the door to close and latch each time it is opened. This deficient could affect 25 residents and staff in 2 smoke compartments when occupied.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director during a tour of the facility on 10/13/22 at 12:50 p.m., the 1 ½ hour rated fire door set to the 600 Wing by resident room 602 was used as a horizontal exit and as a smoke barrier. When tested, the doors failed to latch into the frame due to the doors getting hung up on the coordinator. Based on interview at the time of observation, the Maintenance Director stated the fire door set were not latching into the frame and would need adjustment.<br>.<br>This finding was reviewed with the Maintenance Director during the exit conference.<br><br>3.1-19(b) | K 0226 | **K226 requires horizontal exit fire door sets be arranged to automatically close and latch.**<br>**1.*The corrective action taken for those residents found to have been affected by the deficient practice is:* No residents were affected by this alleged deficient practice. The door set on the 600 hall near resident room 602 has been adjusted and is functioning properly, (See Attachment A)**<br><br>**2. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that:* All residents have the potential to be affected by the alleged deficient practice, thus the following corrective actions have been taken; all fire door sets were assessed to ensure proper closure, (See Attachment B).**<br><br>**3.*The measures that have been put into place to ensure that the* | 10/25/2022 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155524 | A. BUILDING 01<br>B. WING | 10/13/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HEALTH CENTER AT GLENBURN HOME | 618 W GLENBURN ROAD<br>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 |
|---|---|---|---|---|
| | | | ***deficient practice does not recur 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).**<br><br>**4.*The corrective action taken to monitor to ensure the deficient practice will not recur is:* Proper function of the fire doors will be assessed monthly ongoing 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 months, then quarterly until compliance is maintained for two consecutive quarters, (See Attachment D). The plan of action will be adjusted accordingly, as warranted.**<br><br>**5.The above corrective action will be completed on or before October 25, 2022.** | |
| K 0918 SS=F | NFPA 101<br>Electrical Systems - Essential Electric Syste | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155524 | A. BUILDING 01<br>B. WING | 10/13/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HEALTH CENTER AT GLENBURN HOME | 618 W GLENBURN ROAD<br>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 |
|---|---|---|---|---|
| Bldg. 01 | Electrical Systems - Essential Electric System Maintenance and Testing<br>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.<br>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>1. Based on record review and interview, the facility failed to ensure documentation for 1 of 1 emergency generators included a transfer time to the alternate power source on the monthly load | K 0918 | **K918 requires documentation of emergency generators include a transfer time to alternate power source as well** | 10/25/2022 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155524 | A. BUILDING 01<br>B. WING | 10/13/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HEALTH CENTER AT GLENBURN HOME | 618 W GLENBURN ROAD<br>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 |
|---|---|---|---|---|
| | tests during the past 12 months to ensure the alternate power supply was capable of supplying service within 10 seconds. Chapter 6.4.4.1.1.1 of 2012 NFPA 99 requires the generator set or other alternate power source and associated equipment, including all appurtenance parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10 second interval. This deficient practice could affect all residents, as well as staff and visitors in the facility.<br><br>Findings include:<br><br>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 minutes under load, however, the generator form lacked documentation of a transfer time from normal power to emergency power during the past 12 months. At the time of record review, the Maintenance Director agreed that there was no transfer time listed on the monthly generator load test documentation during the past 12 months.<br><br>This finding was reviewed with the Maintenance Director at the exit conference.<br><br>2. Based on record review and interview, the 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 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 | | **as documentation of a 5-minute cool down period after a load test.**<br>**1.*The corrective action taken for those residents found to have been affected by the deficient practice is:* No residents were affected by this alleged deficient practice. The generator has been tested under load with the transfer time and cool down time recorded as required, (See Attachment E).**<br><br>**2. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that:* All residents have the potential to be affected by the alleged deficient practice, thus the following corrective actions have been taken; the generator was tested under load with the transfer time and cool down time recorded as required, (See Attachment E).**<br><br>**3.*The measures that have been put into place to ensure that the deficient practice does not recur is:* As a means to ensure ongoing compliance, facility** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155524 | A. BUILDING 01<br>B. WING | 10/13/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HEALTH CENTER AT GLENBURN HOME | 618 W GLENBURN ROAD<br>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 |
|---|---|---|---|---|
| | the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility.<br><br>Findings include:<br><br>Based on record review with the Maintenance Director on 10/13/22 from 10:24 a.m. to 12:10 p..m., the generator log form documented the generator was tested monthly for at least 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test. Based on interview at the time of record review, the Maintenance Director stated the generator does have a cool down period after running under load, but agreed that a cool down time was not documented on the monthly documentation.<br><br>This finding was reviewed with the Maintenance Director at the exit conference.<br><br>3.1-19(b) | | **maintenance staff were educated on ensuring proper documentation regarding the generator as part of the preventative maintenance program, (See Attachment C).**<br><br>**4.*The corrective action taken to monitor to ensure the deficient practice will not recur is:* Proper documentation of the generator function will be assessed monthly ongoing 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 months, then quarterly until compliance is maintained for two consecutive quarters, (See Attachment F). The plan of action will be adjusted accordingly, as warranted.**<br><br>**5.The above corrective action will be completed on or before October 25, 2022.** | |
| K 0000<br><br>Bldg. 03 | A Life Safety Code Recertification and State | K 0000 | Submission of this plan of | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155524 | A. BUILDING 03<br>B. WING | 10/13/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HEALTH CENTER AT GLENBURN HOME | 618 W GLENBURN ROAD<br>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 |
|---|---|---|---|---|
| K 0000 | Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 10/13/22<br><br>Facility Number: 000230<br>Provider Number: 155524<br>AIM Number: 100275000<br><br>At this Life Safety Code Survey, Health Center at Glenburn Home was found 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 18, New Health Care Occupancies and 410 IAC 16.2.<br><br>This one story addition known as Faith Hall, that was opened in 2019, 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 resident sleeping rooms. The addition has a capacity of 12 and had a census of 12 at the time of this survey.<br><br>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<br><br>Quality Review completed on 10/17/22 | | 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.<br>The Plan of Correction is prepared and submitted because of the requirement under State and Federal law.<br>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.<br><br>Respectfully submitted,<br>Jean Johanningsmeier, HFA<br>Administrator<br>Health Center of Glenburn Home | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155524 | A. BUILDING 04<br>B. WING | 10/13/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| HEALTH CENTER AT GLENBURN HOME | 618 W GLENBURN ROAD<br>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 |
|---|---|---|---|---|
| Bldg. 04 | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 10/13/22<br><br>Facility Number: 000230<br>Provider Number: 155524<br>AIM Number: 100275000<br><br>At this Life Safety Code Survey, Health Center at Glenburn Home was found 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 18, New Health Care Occupancies and 410 IAC 16.2.<br><br>The 800 Wing addition was a one story fully sprinklered building determined to be of Type V (111) construction. This portion of the facility had a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all four resident sleeping rooms. The census of the 800 Wing was zero.<br><br>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.<br><br>Quality Review completed on 10/17/22 | K 0000 | 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.<br>The Plan of Correction is prepared and submitted because of the requirement under State and Federal law.<br>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.<br><br>Respectfully submitted,<br>Jean Johanningsmeier, HFA<br>Administrator<br>Health Center of Glenburn Home | |