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	10/31/2023

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00420338. Complaint IN00420338 - No deficiencies related to the allegation are cited. Survey dates: October 23, 24, 25, 26, 27, 30 and 31, 2023 Facility number: 000230 Provider number: 155524 AIM number: 100275000 Census Bed Type: SNF/NF: 85 SNF: 3 Total: 88 Census Payor Type: Medicare: 4 Medicaid: 65 Other: 19 Total: 88 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 3, 2023.	F 0000	The 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. Please find enclosed the Plan of Correction for this survey. 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 a desk review and paper compliance. Should additional information be necessary to confirm said compliance, please feel free to contact me. Respectfully submitted, Jean Johanningsmeier, RN, HFA Chief Operating Officer	
F 0574 SS=C Bldg. 00	483.10(g)(4)(i)-(vi) Required Notices and Contact Information §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jean Johanningsmeier	RN, HFA, COO	11/20/2023

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	10/31/2023

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
	in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care			

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	10/31/2023

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
	Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.			
	Based on observation, interview, and record review, the facility failed to ensure the known addresses and telephone numbers of the Indiana Department of Health, the office of the Secretary of Family and Social Services, the area agency on aging, the local mental health center, and adult protective service were posted in an area accessible to residents. Findings include: On 10/27/23 at 11:05 a.m., during a resident council meeting, the group indicated they were not	F 0574	F574 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 corrective action taken for those residents who have the potential to be affected by the deficient practice: No residents were affected by this alleged deficient practice. All residents	11/30/2023

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	10/31/2023

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
	informed of their right to nor given information on how to formally complain to the State about the care they received. They also did not know where the Ombudsman's contact information was posted. During an observation on 10/27/23 at 12:01 p.m., a small framed sign was observed approximately 4 and 1/2 feet off of the ground and positioned in a corner where the fire extinguisher was stored. The signage included the phone number and address of the Indiana Department of Health, the office of the Secretary of Family and Social Services, the area agency on aging, the local mental health center, and adult protective service. It was not observed to be in an area that would be easily accessible to residents. During an interview on 10/31/23 at 1:24 p.m., the Activities Director and the Administrator (ADM) indicated the sign was not in a good location for residents and needed to be moved to a more accessible and lower location. On 10/31/23 at 1:50 p.m., and ADM provided a copy of the facility's policy, "RESIDENT RIGHTS," revised on March 15, 2017, and indicated it was the policy currently being used. A review of the policy indicated, "... Information and Communication ... You have the right to receive information from agencies acting as advocates and have the opportunity to contact these agencies ... Grievances. You have the right to voice grievances ... or other agency or entity that hears grievances...with respect to care and treatment ... and other concerns regarding your facility stay..." 3.1-4(j)(3)		have the potential to be affected by this deficient practice, thus the following corrective actions have been taken; the small frame sign was moved to an area that is easily accessible and at a lower level for easy viewing by residents and visitors. The measures that have been put into place to ensure that the deficient practice does not recur is: As a means of ongoing compliance, education has been provided to the Activity Director, Social Services and Administration relating to the requirements of posting required notices and contact information. The corrective action taken to monitor to ensure the deficient practice will not recur is: As a means of quality assurance, the administrator or designee will monitor required notices and contact information postings weekly x 4 weeks, then monthly x 3 months, then quarterly for 3 quarters. The results of the monitoring will be reviewed during the facility's Quality Assurance/Performance Improvement monthly meetings with the plan of action adjusted accordingly, as warranted. The above corrective actions will be completed on or before November 30, 2023.	

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	10/31/2023

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 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is			

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	10/31/2023

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
	required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill			

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	10/31/2023

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
	Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on interview and record review, the facility failed to ensure the written notification required for a transfer and discharge was given to the resident and the resident representative for 2 of 3 residents reviewed. (Resident 43, Resident 89) Findings include: 1. On 10/30/23 at 11:42 a.m., Resident 43's clinical record was reviewed. The diagnosis included, but was not limited to Alzheimer's disease with late onset. Resident 43's progress notes indicated the resident was sent to the hospital on 6/29/23. The Notice of Transfer or Discharge forms dated 6/29/23, lacked documentation the resident and the resident's representative had been notified of the transfer in writing and provided the appeal	F 0623	F623 The corrective action taken for those residents found to have been affected by the deficient practice is: Representatives for residents 43 and 89 were provided with written notification of the past transfer/discharges. One should note both had been provided verbal notification at the time of the transfer. The corrective action taken for those residents found to have been affected by the deficient practice is: All residents have the potential to be affected by this deficient practice, thus the following corrective actions have been taken; an audit was	11/30/2023

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	10/31/2023

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
	rights information in writing including the contact information of the Office of the State LTC (Long Term Care) Ombudsman, after the resident was sent out to the hospital. 2. On 10/30/23 at 11:35 a.m., Resident 89's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus and depression. Resident 89's progress note, dated 10/3/23 at 8:26 a.m., indicated she was transferred to another facility. The clinical record lacked documentation of the resident or the resident's representative being notified in writing the reason of the transfer. During an interview on 10/30/23 at 1:10 p.m., the Administrator indicated the Notice of Transfer or Discharge forms were not sent to the representative in writing. The representative would be notified verbally by phone when a resident was transferred to the hospital. The forms would be sent when the resident goes to the hospital but there was no documentation the resident received it in writing. On 10/30/23 at 1:30 p.m., the Administrator provided the facility policy, "Bed Hold and Return to Facility Policy and Procedure," undated and indicated this was the policy currently being used by the facility. A review of the policy indicated ..."The nurse will obtain the Bed Hold Policy and Return to Facility notice and provide the notice to the resident and their representative at the time of transfer or leave of absence ...The nurse will inform the resident representative, on the telephone if necessary, about the bed hold and return to the facility policy and ask how best to provide a copy of notice to the representative ..."		completed for the previous 30 days of all resident charts. Written notifications were provided to all applicable resident representatives. The measures that have been put into place to ensure that the deficient practice does not recur is: As a means of ongoing compliance education was provided to all licensed nurses, QMAs and social services regarding policies related to notification of transfer/discharge. The corrective action taken to monitor to ensure the deficient practice will not recur is: As a means of quality assurance, the Administrator or Designee will monitor to ensure written notification of transfer/discharge is provided to each resident and their representative, as warranted, weekly x 4 weeks, then monthly x 3 months, then quarterly for 3 quarters. The results of the monitoring will be reviewed during the facility's Quality Assurance/Performance Improvement monthly meetings with the plan of action adjusted accordingly, as warranted. The above corrective actions will be completed on or before November 30, 2023.	

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	10/31/2023

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
	3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(ii) .			
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.			

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	10/31/2023

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
	Based on interview and record review, the facility failed to ensure the notification of the bed-hold policy required for residents who transferred to the hospital was provided in writing to the resident or the residents representative for 1 of 2 residents reviewed for hospitalization. (Resident 43) Findings include: On 10/30/23 at 11:42 a.m., Resident 43's clinical record was reviewed. The diagnosis included, but was not limited to, Alzheimer's disease with late onset. Resident 43's progress notes indicated the resident was sent to the hospital on 6/29/23. There was no documentation that a written notice that specified the facility's bed-hold policy forms were provided to the resident or the resident's representative. During an interview on 10/30/23 at 1:10 p.m., the Administrator indicated the bed-hold policy forms were not sent to the representative in writing. The representative would be notified verbally by phone when a resident was transferred to the hospital. The forms would be sent when the resident goes to the hospital but there was no documentation the resident received it in writing. On 10/30/23 at 1:30 p.m., the Administrator provided the facility policy, "Bed Hold and Return to Facility Policy and Procedure," undated and indicated this was the policy currently being used by the facility. A review of the policy indicated, "... The nurse will obtain the Bed Hold Policy and Return to Facility notice and provide the notice to the resident and their representative at the time of transfer or leave of absence ...The nurse will	F 0625	F625 The corrective action taken for those residents found to have been affected by the deficient practice is: The representative for resident 43 was provided with written notification of the bed hold. One should note the representative had been provided verbal notification at the time of the transfer. The corrective action taken for those residents who have the potential to be affected by the deficient practice: All residents have the potential to be affected by this deficient practice, thus the following corrective actions have been taken; an audit was completed for the previous 30 days of all resident charts. Written notifications were provided to all applicable resident representatives. The measures that have been put into place to ensure that the deficient practice does not recur is: As a means of ongoing compliance education was provided to all licensed nurses, QMAs and social services regarding policies related to notification of facility bed hold policies. The corrective action taken to monitor to ensure the deficient practice will not recur is: As a means of quality assurance the Administrator or Designee will monitor to ensure written	11/30/2023

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	10/31/2023

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
	inform the resident representative, on the telephone if necessary, about the bed hold and return to the facility policy and ask how best to provide a copy of notice to the representative ..." 3.1-12(a)(25) 3.1-12(a)(26)		notification of bed hold is provided to each resident and their representative, as warranted, weekly x 4 weeks, then monthly x 3 months, then quarterly for 3 quarters. The results of the monitoring will be reviewed during the facility's Quality Assurance/Performance Improvement monthly meetings with the plan of action adjusted accordingly, as warranted. The above corrective actions will be completed on or before November 30, 2023	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.			

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	10/31/2023

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
	Based on observation, interview, and record review, the facility failed to identify and respond to an assessed weight loss and failed to implement interventions for 1 of 2 residents reviewed for nutrition. (Resident 61) Findings include: Resident 61's clinical record was reviewed on 10/26/23 at 10:00 a.m. The diagnoses included, but were not limited to, dementia and anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment dated 9/22/23, assessed Resident 61 as being extensive assistance of 1 with eating. Resident 61's weights indicated the following: - On 8/1/23, the resident weighed 121.8 pounds. - On 9/1/23, the resident weighed 122.6 pounds. - On 10/4/23, the resident weighed 122 pounds. - On 10/16/23, the resident weighed 114.8 pounds. - On 10/17/23, the resident weighed 114.8 pounds. This was an assessed 5.90 percent weight loss in 12 days. The clinical record for Resident 61 lacked documentation of an assessment or implementation of a nutritional intervention after the resident was noted to have a weight loss on 10/16/2023. During an observation on 10/26/23 at 12:07 p.m., Resident 61 was observed to be sitting at a table in the dining room. The meal contained a tenderloin sandwich, ice cream, french fries, peach crisp and a coke. Resident 61 was feeding herself but only ate a small amount of ice cream before trying to stand up and roll away from the table in her wheelchair. Certified Nursing Aide (CNA) 1	F 0692	F692 The corrective action taken for those residents found to have been affected by the deficient practice is: The resident identified as Resident 61 was reassessed for nutritional status by the Director of Nursing and Registered Dietician. Revisions were made to the care plan and revised interventions were reviewed with staff involved with care of residents. The corrective action taken for those residents who have the potential to be affected by the deficient practice: No other residents were 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; weight monitoring was conducted on all residents to ensure no other concerns existed and appropriate interventions were in place. The measures that have been put into place to ensure that the deficient practice does not recur is: As a means of ongoing compliance education has been provided to all direct care staff regarding nutritional interventions including weight documentation, monitoring and assisting with meals. The corrective action taken to monitor to ensure the deficient practice will not recur is: As a	11/30/2023

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	10/31/2023

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
	attempted to have the resident sit back down and finish her meal but was unsuccessful. CNA 1 did not attempt to assist the resident with eating. The resident eventually rolled away in her wheelchair down the hall. During an observation on 10/26/23 at 12:14 p.m., CNA 2 was observed to bring Resident 61 back to the table to finish her meal. CNA 2 was observed to tell Resident 61, "I have a cup of coffee for you and that would taste good with the peach crisp wouldn't it?" The resident replied, "yes." CNA 2 fed a bite of the peach crisp to Resident 61 and then walked off saying, "enjoy". Resident 61 was observed to immediately roll away from the table and down the hall. During an observation on 10/27/23 at 12:12 p.m., Resident 61 was observed to be sitting at a table in the dining room. The meal contained beef stew, pie, a roll, ice cream, coffee and coke. Resident 61 was feeding herself and ate 100% of the pie, 1/2 carton of ice cream and 1 bite of the roll before trying to stand up and roll away from the table. Staff were not observed trying to assist resident with feeding or attempting to get her to keep eating. During an interview on 10/27/23 at 10:30 a.m., the Director of Nursing (DON) indicated the computer system would trigger a weight loss and would generate a report for them to discuss in morning meeting. The dietician would also run a report on all the residents in the facility. During an interview on 10/30/23 at 10:23 a.m., the DON indicated they weighed Resident 61 on 10/16/23 and noticed she had a weight loss. She ordered a reweigh for 10/17/23. She was unable to find any notes in the computer for		means of quality assurance, the DON or designee will review each weight report to ensure appropriate measurements, monitor for fluctuations and implement appropriate interventions, as warranted. The DON or designee will complete the monitoring weekly x 4 weeks, then monthly x 3 months, then quarterly for 3 quarters. The results of the monitoring will be reviewed during the facility's Quality Assurance/Performance Improvement monthly meetings with the plan of action adjusted accordingly, as warranted. The above corrective actions will be completed on or before November 30, 2023.	

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	10/31/2023

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
	recommendations and contact with the dietician. During an interview on 10/30/23 at 10:58 a.m., the Dietician indicated she was just looking at Resident 61 that morning for weight loss because she was a monthly weight and had been consistent with her weight for a long time. She did not have any recent progress except for the Quarterly evaluation on 10/3/23 when she had not lost the weight yet. She planned to put interventions in for her weight loss today. On 10/30/23 at 11:30 a.m., Resident 61's clinical record was revewed. A progress note dated 10/30/23 at 10:49 a.m., indicated, "... Resident discussed in NAR [Nutrition at Risk] on 10/17/23 r/t [related to]wt [weight] loss of 7.8# in 30 days. Reweight obtained and is congruent with previous wt. Intake is sporadic with meal consumption averaging 26-50%. RD [Registered Dietician] spoke to nursing about resident preferences. House supps [supplements] ordered TID [three times a day] with meals as resident likes to walk around during meals. Will add he [sic] to NAR for closer monitoring ..." During an interview on 10/30/23 at 1:07 p.m., Registered Nurse 1 indicated she reweighed Resident 61 today and her weighed was 112.6 both standing and in the wheelchair. On 10/30/23 at 11:00 a.m., the Administrator provided the facility's policy, "Weight Monitoring" dated, 11/29/22, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... 4. Interventions will be identified, implemented, monitored and modified [as appropriate] consistent with the resident's assessed needs ... to maintain acceptable parameters of nutritional status ..."			

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	10/31/2023

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
	3.1-46(a)(1)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the			

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	10/31/2023

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
	posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the facility failed to ensure the posted daily nurse staffing information sheet included the facility name, address, and the actual hours worked by licensed staff for 6 of 6 daily staffing sheets reviewed. Findings include: On 10/23/23 at 11:00 a.m., the daily nurse staffing information sheet was observed posted near the receptionist's window. The staffing information sheet lacked documentation of the facility name, address, and the actual hours worked by licensed staff. A review of the posted staffing sheets, dated 10/24/23, 10/25/23, 10/26/23, 10/27/23, 10/28/23, 10/29/23, 10/30/23, and 10/31/23 indicated the staffing information sheets lacked documentation of the facility name, address, and the actual hours worked by licensed staff. During an interview on 10/31/23 at 1:33 p.m., the staffing coordinator indicated she updated the staffing sheet in her computer to reflect the actual hours worked by staff the next day, but she did not know it should be on the posted form. She further indicated the name and address of the facility should be on the sheet and she would updated the form.	F 0732	F732 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 corrective action taken for those residents who have the potential to be affected by the deficient practice: No residents were 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; the posted staffing form was updated to include all required information. The measures that have been put into place to ensure that the deficient practice does not recur is: As a means of ongoing compliance, education was provided to the DON, ADON and Staff Scheduler regarding the requirements of the Nurse Staffing Posting. The corrective action taken to monitor to ensure the deficient practice will not recur is: As a means of quality assurance, the DON or designee will monitor the Nurse Staffing Posting weekly x 3 weeks, then monthly x 3 months, then quarterly for 3 quarters. The results of the monitoring will be	11/30/2023

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	10/31/2023

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
			reviewed during the facility's Quality Assurance/Performance Improvement monthly meetings with the plan of action adjusted accordingly, as warranted. The above corrective actions will be completed on or before November 30, 2023.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food was stored in a sanitary manner for 3 of 3 kitchen observations. Expired food was not discarded, juice in damaged cans were not separated for return, and food was stored beneath a leaking	F 0812	F 812 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	11/30/2023

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	10/31/2023

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
	condenser. Findings include: During tours of the facility kitchen on 10/24/23 at 1:55 P.M., 10/26/23 at 10:45 A.M., and 10/27/23 at 12:30 P.M., the following was observed: 1. On a shelf in the walk-in refrigerator were two 5 pound containers of cottage cheese with the best by date of 10/23/23. 2. In the walk-in freezer, beneath a condenser upon which water had leaked and formed ice was an open 29.7 pound box of biscuit dough upon and within which ice had fallen. 3. In the kitchen dry stock room, on the shelving unit upon which multiple canned goods were stored for consumption were three 46 ounce cans of pineapple juice. The double seal edges of the cans were deeply dented. During an interview on 10/27/23 at 2:20 P.M., the facility administrator indicated the expired cottage cheese should have been discarded, food should not have been stored beneath a leaking condenser, and the dented cans of pineapple juice should have been removed from the canned goods shelving unit. On 10/31/23 at 10:22 A.M., the facility administrator provided the Food and Supply Storage policy, revised date of January 2022 and indicated this was the policy used by the facility. A review of the policy indicated, "...foods past the...best by date should be discarded...maintain designated area for items that are damaged (such as dented cans)..."		practice. The corrective action taken for those residents who have the potential to be affected by the deficient practice. No residents were affected by this alleged deficient practice. All residents have the potential to be affected by this deficient practice, thus the following corrections actions have been taken; food that was expired, in damaged packaging or stored under the leaking condenser was discarded. The measures that have been put into place to ensure that the deficient practice does not recur is: As a means of ongoing compliance, education was provided to all dietary employees regarding food storage and safety. The corrective action taken to monitor to ensure the deficient practice will not recur is: As a means of quality assurance, the Dietary Manager or designee will monitor for appropriate storage of food products weekly x 4 weeks, then monthly x 3 months, then quarterly for 3 quarters. The results of the monitoring will be reviewed during the facility's Quality Assurance/Performance Improvement monthly meetings with the plan of action adjusted accordingly, as warranted. The above corrective actions will be completed on or before November 30, 2023.	

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	10/31/2023

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
	On 10/31/23 at 1:05 P.M., a review of the Indiana State Department of Health Retail Food Establishment Sanitation Requirements manual, effective date November 13, 2004 indicated, "...410 IAC 7-24-178 Food storage; prohibited areas Sec. 178. (a) Food may not be stored as follows:...(2) Under the following:...under lines on which water has condensed...410 IAC 7-24-202...products that are held by the owner or operator in a retail food establishment for credit, redemption, or return to the distributor, such as damaged...products, shall be segregated and held in designated areas that are separated from (1) food..." 3.1-21(i)(2) 3.1-21(i)(3)			