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

FORM APPROVED
OMB NO. 0938-039

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	11/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTH CENTER AT GLENBURN HOME	618 W GLENBURN ROAD LINTON, IN 47441

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/13/23 Facility Number: 000230 Provider Number: 155524 AIM Number: 100275000 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 The facility has a capacity of 149 certified beds and had a census of 91 at the time of this visit. Quality Review completed on 11/15/23	E 0000		
K 0000 Bldg. 01	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). Survey Date: 11/13/23 Facility Number: 000230 Provider Number: 155524 AIM Number: 100275000 At this Life Safety Code Survey, Health Center at	K 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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jean Johanningsmeier	HFA	12/12/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	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. 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 91 at the time of this survey. 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. Quality Review completed on 11/15/23		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	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review and interview; the facility failed to document annual testing for all battery backup lights in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly,	K 0291	K291 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.	11/20/2023

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	with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Maintenance Supervisor and Environmental Services Director at 2:20 p.m. on 11/13/23, annual battery operated light testing documentation for the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated the Maintenance Assistant tests the battery operated lights for 30 seconds monthly and 90 minutes annually, but agreed documentation of an itemized listing for an annual 90-minute testing for all battery operated light locations in the facility within the most recent twelve month period was not available for review. This finding was reviewed with the Administrator, CEO, Maintenance Supervisor and Environmental Services Director during the exit conference.		The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that: No residents were affected by this alleged deficient practice. All residents have the potential to be affected by the deficient practice, thus the following corrective actions have been taken; a 90-minute test of all battery operated lights was conducted, (See Attachment A). 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 facility Maintenance Director regarding the requirements of annual 90-minute testing of battery operated lights, (See Attachment B). The corrective action taken to monitor to ensure the deficient practice will not recur is: As a means of quality assurance, proper documentation of the annual testing will be monitored ongoing as part of the facility preventative maintenance program. The PM logs will continue to be monitored as part of the facility quality assurance/performance improvement program, ongoing,	

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	3.1-19(b)		with the plan of action adjusted accordingly, as warranted. The above corrective action will be completed on or before November 20, 2023	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 6 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect as many as 50 residents, staff and visitors in one smoke compartment. Findings include:	K 0374	K374 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 other residents that have the potential to be affected by the same deficient practice is that: No residents were affected by this	11/20/2023

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	Based on observation with the Maintenance Supervisor and Environmental Services Director during a tour of the facility on 11/13/23 from 12:55 p.m. to 2:20 p.m., the 1 ½ hour rated fire door set to the 400 Wing by resident room 408 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 Supervisor agreed the fire door set was not latching into the frame and would need adjustment. This finding was reviewed with the Administrator, CEO, Maintenance Supervisor and Environmental Services Director during the exit conference. 3.1-19(b)		alleged deficient practice. All residents have the potential to be affected by the deficient practice, thus the following corrective actions have been taken; the coordinator on the fire door set to the 400 hall by resident room 408 was replaced and is functioning appropriately. 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 facility Maintenance Director regarding the proper function of all fire doors, (See Attachment B). The corrective action taken to monitor to measure the deficient practice will not recur is: As a means of quality assurance, the appropriate function of fire doors will continue to be monitored as part of the facility preventative maintenance program. The PM logs will be reviewed for compliance as part of the facility quality assurance/performance improvement meeting on a monthly basis, ongoing, with the plan of action adjusted accordingly as warranted. The above corrective actions will be completed on or before November 20, 2023.	

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K 0920 SS=B Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5			
	Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect staff in the	K 0920	K920 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.	11/20/2023

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	vicinity of the Scheduling office. Findings include: Based on observations during a tour of the facility with the Maintenance Supervisor and Environmental Services Director on 11/13/23 at 1:00 p.m., a refrigerator (high power draw equipment) and microwave was plugged into and supplied power by a power strip in the Scheduling office. Based on interview at the time of observation, the Maintenance Supervisor confirmed a power strip was supplying power to a refrigerator and microwave and removed the power strip upon observation. This finding was reviewed with the Administrator, CEO, Maintenance Supervisor and Environmental Services Director at the exit conference. 3.1-19(b)		The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is: 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 power strip was removed from the scheduling office. 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 facility Maintenance Director regarding the use of power strips for high draw equipment, (See Attachment B). The corrective action taken to monitor to ensure the deficient practice will not recur is: As a means of quality assurance, monitoring for the improper use of power strips will continue as part of the facility preventative maintenance program, ongoing. The PM logs will continue to be monitored as part of the facility quality assurance/performance improvement program, ongoing, with the plan of action adjusted accordingly, as warranted. The above corrective actions will	

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			be completed on or before November 20, 2023.	