STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		x1) provider/supplier/clia identification number 155524	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 03/10/2022	
NAME OF	PROVIDER OR SUPPLIE	ËR			ADDRESS, CITY, STATE, ZIP COD / GLENBURN ROAD		
HEALTH	CENTER AT GLE	NBURN HOME		LINTO	N, IN 47441		
(X4) ID PREFIX		7 STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	L	(X5) COMPLETION
TAG		DR LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE
0000				1/10			DAIL
Bldg. 00		the Investigation of Complaints N00374092. This visit included a	F 00	)00	Submission of this plan of		
	COVID-19 Focuse	ed Infection Control Survey.			Submission of this plan of correction does not constitute admission or agreement by t		
	-	73343 - Substantiated. No d to the allegations are cited.			provider of the truth of facts alleged or correction set forth the Statement of Deficiencies		
	Complaint IN0037	74092 - Substantiated.			The Plan of Correction is pre		
	-	ciencies related to the			and submitted because of th		
	allegations are cite	ed at F888.			requirement under State and Federal law.		
	Survey dates: Mar	ch 9 and 10, 2022			Please accept this Plan of Correction as our credible		
	Facility number: 0	00230			allegation of compliance effe	ctive	
	Provider number:	155524			April 1, 2022. Please find		
	AIM number: 1002	275000			enclosed the Plan of Correct the survey dated March 9-10		
	Census Bed Type:				2022. Due to the low scope		
	SNF/NF: 97				severity of the survey finding	s,	
	Total: 97				please find the sufficient documentation providing evid	dence	
	Census Payor Typ	e:			of compliance with the Plan	of	
	Medicare: 8				Correction. The documentat		
	Medicaid: 67				serves to confirm the Facility		
	Other: 22				allegation of compliance. Th		
	Total: 97				the Facility respectfully reque		
	This definition	flacts State Findings sited in			the granting of paper complian Should additional information		
	accordance with 4	flects State Findings cited in			necessary to confirm said	ine	
		10 11 10 10.2-5.1.			compliance, please feel free	to	
	Quality review con	mpleted on March 15, 2022.			contact me.		
					Respectfully submitted, Jean Johanningsmeier, HFA Administrator Health Center of Glenburn H		

## LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 03/31/2022

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 03/10/2022 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 F 0888 483.80(i)(1)-(3)(i)-(x) SS=D COVID-19 Vaccination of Facility Staff Bldg. 00 §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the ZLZ011 Event ID: Facility ID: 000230 Page 2 of 7 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 03/10/2022 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 DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; ZLZ011 Event ID: Facility ID: 000230 Page 3 of 7 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 03/10/2022 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 DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment: and ZLZ011 Facility ID: 000230 Page 4 of 7 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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ful Ef §4 all se ex of CO de to Ba fai va ed un de wi no Fi 1. Er CO ad un Du Er CO ad un Du Er CO ad un A va ex se ex se ex of CO de to Ba fai va ex ex ex ex ex of CO de to Ba fai va ex ex ex ex ex ex ex ex ex ex	Ily vaccinated f fective 60 Day 83.80(i)(3)(ii) staff specified action are fully coept for those semptions to th this section, of OVID-19 vaccin elayed, as reco- clinical precau ased on interview iled to develop p faction would b twaccinated staff adline for staff in that actions would that actions actions that ac	s After Publication: A process for ensuring that in paragraph (i)(1) of this vaccinated for COVID-19, staff who have been granted e vaccination requirements r those staff for whom nation must be temporarily mmended by the CDC, due tions and considerations; v and record review, the facility policies and procedures for staff policy lacked what type of e provided quarterly to members, failed to have a nembers to be vaccinated, and d be taken if the deadline was view on 3/10/2022 at 1:10 p.m., atted she was not vaccinated for d no knowledge of what on was required quarterly for members. w on 3/10/2022 at 1:15 p.m., atted she was not vaccinated for d no knowledge of what on was required quarterly for	F 0888	<ul> <li>F888 requires the facil develop and implement policies and procedure ensure that all staff are vaccinated for COVID-1. The corrective action those residents found been affected by the depractice is: No residen affected by this alleged practice.</li> <li>2. The corrective action for the other residents the potential to be affected by the affected by this alleged practice.</li> <li>2. The corrective action for the other residents the potential to be affected by and that: All resident practice following corrective action for the other same deficient practice following corrective action for the other second been taken; a review of employee records has be completed to ensure ead employee was either full vaccinated, scheduled to a vaccine series when e has an approved exemplate the same deficient practice is a proved exemplement of the second been taken approved exemplement of the</li></ul>	t s to fully 19. taken for to have eficient ts were deficient ts were deficient that have cted by ctice is the by the e, thus the ons have all een ch y c complete ligible, or	04/01/202	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

ENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
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				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	ĸ		618 W			
HEALTH	CENTER AT GLE	NBURN HOME		LINTO	N, IN 47441		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	JATE	DATE
					(See Attachment A).		
	The policy lacked	additional information on what					
	specific continuing	g education the facility would					
	provide for unvacc	vinated/exempted staff members.			3. The measures that have	been	
					put into place to ensure the	at the	
	During an interview	w on 3/10/2022 at 2:25 p.m.,			deficient practice does not	recur	
	Employee 3 indica	ted the facility planned to			is: As a means to ensure on	going	
	provide additional	education for			compliance the facility policie	es	
	unvaccinated/exem	npted staff members however,			regarding employee vaccina	tions	
	the policy was not	specific on what that education			and vaccine exemptions wer	e	
	would be. 2. The E	Employee COVID-19 Vaccination			reviewed and updated to inc	lude	
	Exemption Policy,	dated 3/1/2022, lacked			specific quarterly education		
	documentation of a	a deadline for staff to be			requirements for unvaccinate	ed	
	vaccinated and wh	at actions would be taken if			staff, specific timeframes for	the	
	deadline was not n	net.			completion of vaccine series	or	
					exemptions and what actions	S	
	During an interview	w at 3/10/22 at 2:45 p.m.,			would be taken if these		
	Employee 3 indica	ted the policy lacked			requirements were not comp	leted	
	documentation of o	deadline for staff to be			timely, (See Attachment B).	All	
	vaccinated and wh	at action taken if deadline was			unvaccinated employees wil	l be	
	not met.				educated regarding the facili	ty's	
					additional requirements for	-	
	This Federal tag re	elates to Complaint IN00374092.			individuals with religious or		
					medical exemptions for the		
	3.1-18(b)(1)				COVID-19 vaccine.		
					4.The corrective action tak	en to	
					monitor to ensure the defic		
					practice will not recur is: A		
					Quality Assurance tool has to		
					developed and implemented monitor documentation of all		
						пеміу	

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ZLZ011

Facility ID: 000230

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hired employee vaccinations and/or exemptions to ensure timely compliance, (See Attachment C). This tool will be completed by the Infection Control Preventionist or designee weekly x

4 weeks, then monthly x 3 months, and then quarterly for 3

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	OF HEALTH AND HU	AID SERVICES			PRINTED: 03/3 FORM APPROV OMB NO. 0938-1	
	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155524	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/10/2022	
	ROVIDER OR SUPPLIEI		618 W	ADDRESS, CITY, STATE, ZIP COD V GLENBURN ROAD N, IN 47441		
PREFIX (EACH DEFICIE	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR TAG DEFICIENCY)		E (X5) COMPLET DATE	
				<ul> <li>quarters. An additional Qual Assurance tool has been developed and implemented monitor for compliance with quarterly education of individ with religious or medical exemption for the COVID-19 vaccine, (See Attachment D) This tool will be completed b Infection Control Preventioni designee at the end of each quarter, (i.e. March, June, September, and December) ensure all education requirer have been met. The outcom these tools will be reviewed a facility's Quality Assurance meetings with the plan of act adjusted accordingly, as warranted.</li> <li>5. The above corrective actio be completed on or before A 2022.</li> </ul>	to luals ). y the st or to ments nes of at the tion	

Event ID:

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Facility ID: 000230

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