STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155759	A. BUILDING -- B. WING	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLEN OAKS HEALTH CAMPUS	601 W CR 200 S NEW CASTLE, IN 47362

(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 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/29/24 Facility Number: 011187 Provider Number: 155759 AIM Number: 200838150 At this Emergency Preparedness survey, Glen Oaks Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 68 certified beds. At the time of the survey, the census was 52. Quality Review completed on 08/30/24	E 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey visit with exit on August 29th, 2024.	
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: 08/29/24 Facility Number: 011187 Provider Number: 155759 AIM Number: 200838150 At this Life Safety Code survey, Glen Oaks Health Campus was found not in compliance with	K 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tammy R Nelson	Executive Director	09/11/2024

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	155759	A. BUILDING 01 B. WING	08/29/2024

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GLEN OAKS HEALTH CAMPUS	601 W CR 200 S NEW CASTLE, IN 47362

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	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 (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, hard wired smoke detectors in all resident rooms in the building. The facility has a capacity of 68 and had a census of 52 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 08/30/24		cited during the survey visit with exit on August 29th, 2024.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through 1 of over 6 delayed egress locks was readily accessible for all residents, staff, and visitors. LSC 7.2.1.6.1. (3) (4) states a readily visible, durable sign in letters not less than 1 in. (25mm) high and not less than 1/8 in. (3.2mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect 15 residents. Findings include:	K 0222	**K 222 - Egress Doors NFPA 101** **Immediate Intervention** The Director of Plant Operations has replaced missing signage indicating PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPEND IN 15 SECONDS this deficient practice could affect 15 residents. **Exhibit A – photo** **Compliance Date** **9-13-24**	09/13/2024

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	Based on observations and interview during a facility tour with the Plant Operations Director and Facilities Support Representative on 08/29/24 between 10:10 a.m. and 12:15 p.m., the main exit door located in the front lobby was provided with delayed egress locks but lacked the proper signage indicating the doors can be opened in 15 seconds by pushing on the door. Based on interview at the time of observation, the Plant Operations Director acknowledged the door was equipped with a delayed egress and lacked the proper signage. The Plant Operations Director stated that the door is not locked during the day, and is only locked at night. This finding was acknowledged by the Plant Operations Director at the time of discovery and again at the exit conference with the Plant Operations Director and Facilities Support Representative present. 3.1-19(b)		The Director of Plant Operations and maintenance staff has been educated by the Regional Support on maintaining the visual signage on egress locks to ensure accessibility for all residents, staff, and visitors. A durable sign with letters not less than 1" high and not less than 1/8" stroke width on a contrasting background in accordance with LSC 7.2.1.6.1 (3) (4) **Exhibit B – Inservice** The Director of Plant Operations will perform weekly visual inspection x 3 months documentation will be housed in TELS. Executive Director will present results of visual inspections to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 4 staff and residents. Findings include:	K 0363	**K363 – Corridor – Doors** **Immediate intervention** Adjusted the closer attached to the door that would have prevented	09/13/2024

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	Based on observations and interview during a facility tour with the Plant Operations Director and Facilities Support Representative on 08/29/24 between 10:10 a.m. and 12:15 p.m., the corridor door to the Computer Room, equipped with a self-closing device, failed to self-close close and latch positively into the door frame. This finding was acknowledged by the Plant Operations Director at the time of discovery and again at the exit conference with the Plant Operations Director and Facilities Support Representative present. 3.1-19(b)		keeping closed, had no impediment to closing, latching and would resist the passage of smoke that could affect 4 staff and residents to meet K363 deficiency. **Compliance date** **9/13/2024** The Director of Plant Operations was educated by Regional Support on K363 corridor – doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas to resist the passage of smoke as it pertains NFPA 101 in compliance with 7.2.1.9, 19.3.6.3.6, 8.3, 19.3.6.3, 42 CFR parts 403,418,460,482,483 and 485. **Exhibit B – Inservice** The Director of Plant Operations or assigned party will visually inspect the corridor doors weekly. **Exhibit C - Audit tool** Executive Director will present results of visual inspection thru the QAPI committee for further recommendations and will continue until QAPI team	

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			determines substantial compliance has been achieved.	