

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155176	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/12/2016
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NAME OF PROVIDER OR SUPPLIER GLENBROOK REHABILITATION & SKILLED NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3811 PARNELL AVE FORT WAYNE, IN 46805
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00203796.</p> <p>Complaint #IN00203796 - substantiated. Federal/State deficiencies related to the allegations are cited at F465.</p> <p>Survey dates: July 5, 6, 7, 8, 11, and 12, 2016</p> <p>Facility number: 000092 Provider number: 155176 AIM number: 100266090</p> <p>Census bed type: SNF/NF: 69 Total: 69</p> <p>Census payor type: Medicare: 7 Medicaid: 58 Other: 4 Total: 69</p> <p>These deficiencies reflect state findings in accordance with 410 IAC 16.2 -3.1.</p> <p>QR completed on July 14, 2016 by 17934.</p>	F 0000	<p>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. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.</p> <p><u>Requesting Desk Review</u></p>	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to follow care plans for 1 of 1 residents (#75) reviewed for meal service care plans.</p> <p>Findings include:</p> <p>During a meal observation on 7/8/16 at 11:57 A.M., Resident #75 stated she could not eat her meal as served. Resident #75, who is alert, oriented, and visually impaired, stated she was to receive her food in separate bowls. Resident #75's entree was a sloppy joe sandwich cut in half on a plate. The sloppy joes were overflowing the bun and the resident indicated she would make a mess if she tried to eat it off of the plate. Resident #75 indicated she had been in the facility for several months and she stated not getting her food in bowls happened often.</p> <p>Resident #75's meal ticket was on the table near her and indicated food was to be served in bowls.</p>	F 0282	<p>Requesting Desk Review F 282</p> <p>1. Physician was notified for resident # 75. 2. All residents had the potential to be affected by this practice. Please note that resident # 75 had no negative outcome and there were no other residents affected. IDT reviewed residents care plan, physician's orders and tray card and ensured all is accurate. A house wide audit was completed by the DNS/Designee to ensure all care plans and tray cards were followed in the dining room with no further concerns noted. The physician was notified for the resident in question regarding the resident not having her food in bowls. 3. The dietary department and nursing department was educated on F282 and following a care plan on 7-18-16 by the ED/Designee. Nurse on duty to review tray card prior to resident being served meal. 4. To ensure compliance the Dietary Manager/Designee is responsible for the completion of the meal observation CQI tool weekly times 4 weeks, bi monthly times 2 months and then</p>	07/25/2016

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F 0465 SS=E Bldg. 00	<p>Review of Resident #75's care plan dated 4/26/16 for nutritional status indicated she was legally blind and the facility was to provide food in bowls/dish to aid in self feeding.</p> <p>3.1-35(g)(2)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure closet doors in resident rooms were functional in 19 of 39 resident rooms.</p> <p>Findings include:</p> <p>On 7/6/2016 at 9:50 A.M., a tour of all resident rooms in the facility was conducted with the Executive Director (ED). All rooms were observed to have closets designed to have two sliding doors, supported with tracks at the top of the doors and guides at the bottom of the doors. During the tour, the following were observed:</p> <p>Room 103 - both closet doors were off of the rails at the top and could not be easily</p>	F 0465	<p>quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. 5. Completion date: 7-25-16.</p> <p>Requesting Desk Review F465 1. Closet doors in the rooms of the residents in question were immediately removed or replaced. 2. All residents had the potential to be affected by this practice. Please note that the residents in question had no negative outcomes from this practice. A house wide audit was completed to ensure all remaining closet doors were in compliance with F 465. 3. The Maintenance Director was educated on F 465 by the ED/Designee on 7-18-16. All closet doors in the facility will be replaced in accordance with F465. 4. To ensure compliance, the Maintenance Director will be responsible for the completion of a CQI audit tool to ensure all closet doors are functioning and will oversee the remodel of all</p>	07/25/2016

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	<p>opened.</p> <p>Room 105 - one closet door was missing.</p> <p>Room 106 - one closet door was off of the rails at the top and could not be easily opened and one door was missing.</p> <p>Room 108 - both closet doors were off of the rails at the top and could not be easily opened.</p> <p>Room 109 - one closet door was missing.</p> <p>Room 110 - both closet doors were off the rails at the top and could not be easily opened.</p> <p>Room 111 - both closet doors were off the rails at the top and could not be easily opened.</p> <p>Room 202 - both closet doors were missing.</p> <p>Room 204 - both closet doors were off the rails at the top and could not be easily opened.</p> <p>Room 208 - both closet doors were off the rails at the top and could not be easily opened.</p> <p>Room 210 - both closet doors were off the rails at the top and could not be easily opened.</p> <p>Room 216 - one closet door was off of the rails at the top and could not be easily opened and one door was missing.</p> <p>Room 217 - both closet doors were off the rails at the top and could not be easily opened.</p> <p>Room 224 - both closet doors were off the rails at the top and could not be easily</p>		<p>closet doors. The CQI tool will be completed weekly x 4 weeks, bi monthly times 2 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. 5. Completion date: 7-25-16</p>				

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	<p>opened.</p> <p>Room 226 - both closet doors were off the rails at the top and could not be easily opened.</p> <p>Room 228 - both closet doors were missing.</p> <p>Room 230 - both closet doors were off the rails at the top and could not be easily opened.</p> <p>Room 231 - both closet doors were off the rails at the top and could not be easily opened.</p> <p>Room 232 - both closet doors were off the rails at the top and could not be easily opened.</p> <p>The facility Maintenance Supervisor was interviewed on 7/6/2016 at 9:55 A.M. During the interview, the Maintenance Supervisor indicated the the problem with the closet doors coming off of the rails was an on-going problem. The Maintenance Supervisor further indicated he would start each day at work re-hanging as many of the closet doors as he could, but they would eventually come back off of the upper rails. He indicated the facility had taken some of the doors down, as they frequently came off of the upper rails. The Maintenance Supervisor also indicated the rails and guide tracks on the closets had been replaced and the doors re-hung approximately six months ago, but the doors still came off of the</p>			

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F 0520 SS=E Bldg. 00	<p>rails.</p> <p>Resident #33 was interviewed on 7/6/2016 at 10:10 A.M. During the interview, Resident #33 indicated the doors to her closet came off the upper rails frequently and had been an on-going problem.</p> <p>Resident #53 was interviewed 7/6/2016 at 10:15 A.M. During the interview, Resident #53 indicated the closet doors did not work properly and there were times he could not get into his closet.</p> <p>During the tour of the resident rooms, the ED indicated she was new to the facility and did not know the history of the problem with the doors and that the doors would need to be replaced.</p> <p>This Federal tag relates to Complaint IN00203796.</p> <p>3.1-19(f)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p>			

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	<p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation and interview, the facility's Continuous Quality Improvement (CQI) Committee failed to ensure closet doors in resident rooms were functional in 19 of 39 resident rooms.</p> <p>Findings include:</p> <p>On 7/6/2016 at 9:50 A.M., a tour of all resident rooms in the facility was conducted with the Executive Director (ED). All rooms were observed to have closets designed to have two sliding doors, supported with tracks at the top of the doors and guides at the bottom of the</p>	F 0520	<p>Requesting Desk Review F520</p> <p>1. Closet doors in the rooms of the residents in question were immediately removed or replaced.</p> <p>2. All residents had the potential to be affected by this practice. Please note that the residents in question had no negative outcomes from this practice. A house wide audit was completed to ensure all remaining closet doors were in compliance with F 465. 3. The IDT team was educated by the ED on 7-25-16 on F520 and CQI policy. ED to ensure results of audits are reviewed by the CQI committee and threshold of 95% is achieved. If threshold is not met,</p>	07/25/2016

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	<p>doors. During the tour, the following were observed:</p> <p>Room 103 - both closet doors were off of the rails at the top and could not be easily opened.</p> <p>Room 105 - one closet door was missing.</p> <p>Room 106 - one closet door was off of the rails at the top and could not be easily opened and one door was missing.</p> <p>Room 108 - both closet doors were off of the rails at the top and could not be easily opened.</p> <p>Room 109 - one closet door was missing.</p> <p>Room 110 - both closet doors were off the rails at the top and could not be easily opened.</p> <p>Room 111 - both closet doors were off the rails at the top and could not be easily opened.</p> <p>Room 202 - both closet doors were missing.</p> <p>Room 204 - both closet doors were off the rails at the top and could not be easily opened.</p> <p>Room 208 - both closet doors were off the rails at the top and could not be easily opened.</p> <p>Room 210 - both closet doors were off the rails at the top and could not be easily opened.</p> <p>Room 216 - one closet door was off of the rails at the top and could not be easily opened and one door was missing.</p>		<p>an Action Plan will be developed to ensure compliance. 4. To ensure compliance, the Maintenance Director will be responsible for the completion of a CQI audit tool to ensure all closet doors are functioning and will oversee the remodel of all closet doors. The CQI tool will be completed weekly x 4 weeks, bi monthly times 2 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. 5. Completion date: 7-25-16</p>		

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	<p>Room 217 - both closet doors were off the rails at the top and could not be easily opened.</p> <p>Room 224 - both closet doors were off the rails at the top and could not be easily opened.</p> <p>Room 226 - both closet doors were off the rails at the top and could not be easily opened.</p> <p>Room 228 - both closet doors were missing.</p> <p>Room 230 - both closet doors were off the rails at the top and could not be easily opened.</p> <p>Room 231 - both closet doors were off the rails at the top and could not be easily opened.</p> <p>Room 232 - both closet doors were off the rails at the top and could not be easily opened.</p> <p>The facility Maintenance Supervisor was interviewed on 7/6/2016 at 9:55 A.M. During the interview, the Maintenance Supervisor indicated the the problem with the closet doors coming off of the rails was an on-going problem. The Maintenance Supervisor further indicated he would start each day at work re-hanging as many of the closet doors as he could, but they would eventually come back off of the upper rails. He indicated the facility had taken some of the doors down, as they frequently came off of the</p>			

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	<p>upper rails. The Maintenance Supervisor also indicated the rails and guide tracks on the closets had been replaced and the doors re-hung approximately six months ago, but the doors still came off of the rails.</p> <p>Resident #33 was interviewed on 7/6/2016 at 10:10 A.M. During the interview, Resident #33 indicated the doors to her closet came off the upper rails frequently and had been an on-going problem.</p> <p>Resident #53 was interviewed 7/6/2016 at 10:15 A.M. During the interview, Resident #53 indicated the closet doors did not work properly and there were times he could not get into his closet.</p> <p>During the tour of the resident rooms, the ED indicated she was new to the facility and did not know the entire history of the problem with the closet doors and the doors would need to be replaced.</p> <p>The ED was interviewed on 7/12/16 at 12:30 P.M. During the interview, the ED indicated the facility's CQI Committee met monthly to identify and address potential quality concerns, including environmental concerns. An invoice dated January 19, 2015, was provided by the ED. The invoice indicated the facility</p>			

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	<p>had received a quote to repair the closet doors, to be done with other renovations to the facility. The ED indicated the facility had made the repairs to the closet doors, but the doors continued to be a concern. The ED further indicated there was no documentation to indicate the facility's CQI Committee had addressed the problem with the closet doors since then.</p> <p>An untitled and undated facility policy on the quality improvement process was provided by the ED on 7/12/16 at 12: 45 P.M. The ED indicated the policy was current. The policy indicated "It is the standard of (facility corporate name) that each facility actively participates in a formalized and documented Quality Improvement Process. The process is comprehensive (involving all departments and key facility practices) and includes monitoring, evaluation, and appropriate follow-up action to continually improve and provide excellent service. Quality improvement is an ongoing process designed to improve present levels of care and services to provide optimal health opportunity to the residents."</p> <p>3.1-52(b)(2)</p>			

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

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