

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155176	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/03/2016
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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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K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/03/16</p> <p>Facility Number: 000092 Provider Number: 155176 AIM Number: 100266090</p> <p>At this Life Safety Code survey, Glenbrook Rehabilitation and Skilled Nursing Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a basement was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. Battery operated smoke detectors have been installed in the resident rooms. The</p>	K 0000	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.	
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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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K 0025 SS=E Bldg. 01	<p>facility has a capacity of 82 and had a census of 64 at the time of this survey.</p> <p>All areas where the residents have customary access are sprinklered. All areas providing facility services are sprinklered.</p> <p>Quality Review completed on 08/08/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>1. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 6 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the</p>	K 0025	<p>1. There were no residents affected by this practice. The penetrations in the attic by room 214, the ceiling of 300 hall nurses station, and the ceiling of the conference room were all sealed with fire caulk.</p> <p>2.All residents have the potential to be affected by this practice. A house wide audit was completed by the Maintenance Director to ensure all ceiling penetrations were sealed.</p> <p>3.The Maintenance Director was educated by the Executive Director on 8-3-16 related to unsealed penetrations. The</p>	08/10/2016

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	<p>smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect up to 40 residents in 2 of 7 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Environmental Supervisor on 08/03/16 from 11:40 a.m. to 12:15 p.m., in the attic of the smoke barrier wall by room 214 there was an unsealed one foot by one foot hole with a sprinkler line running through the hole. Based on interview at the time of observation, the Environmental Supervisor acknowledged and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 26 residents in one of 2 of 7 smoke compartments.</p>		<p>Maintenance Director and the Executive Director did rounds to ensure that all penetrations have been sealed. Any ceiling penetrations will be inspected by the Maintenance Director following the service of vendors to ensure the ceiling smoke barriers are sealed.</p> <p>4. The Maintenance Director/Designee will complete rounds to ensure all ceiling penetrations are sealed with fire caulk daily x 4 weeks then weekly x 4 weeks then monthly for at least 6 months. The Executive Director will monitor that rounds are completed and that all ceiling penetrations are sealed daily x 4 weeks then weekly x 4 weeks then monthly for at least 6 months. The results of the monitoring will be forwarded to the CQI committee.</p> <p>5. Completion Date 8-10-16 REQUESTING DESK REVIEW</p>	

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K 0029 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on observation during a tour of the facility with the Environmental Supervisor on 08/03/16 from 10:30 a.m. to 11:40 a.m., the following areas had unsealed penetrations:</p> <ol style="list-style-type: none"> 1. In the ceiling of 300 hall nurse ' s station there were two unsealed fourth of an inch penetrations around conduits. 2. In the ceiling of conference room there was an unsealed fourth of an inch penetration around a data wire. <p>Based on interview at the time of observation, the Environmental Supervisor acknowledge and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>1. Based on observation and interview,</p>	K 0029	1. There were no residents affected by this practice. .	08/10/2016			

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	<p>the facility failed to ensure 1 of 3 kitchen doors automatically closed and latched into the door frame. This deficient practice was not in a resident care area but could affect staff in the kitchen and service hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Environmental Supervisor on 08/03/16 at 9:10 a.m., the door going in from the service hall to the kitchen did not automatically close and latch into the door frame due to door sticking on the floor. Based on interview, this was acknowledged by the Environmental Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms, a hazardous area, was smoke resistive. This deficient practice could affect 5 residents outside of the laundry room.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Environmental Supervisor on 08/03/16 at 10:13 a.m., in</p>		<p>Hardware has been repaired on the kitchen service door to allow for compliance of K029. The penetration around the pipe in the laundry room has been sealed with fire caulk.</p> <p>2.All residents have the potential to be affected by this practice. All other doors were examined by the Maintenance Director to ensure compliance with K029. A housewide audit was completed by the Maintenance Director to ensure all penetrations were sealed.</p> <p>3.The Maintenance Director was educated on K029 on 8-3-16 by the Executive Director. All other doors were examined by the Maintenance Director to ensure compliance with K029. The Maintenance Director was educated on ensuring all penetrations are sealed with fire caulk. Rounds were completed by the ED and the Maintenance Director to ensure that all penetrations have been sealed.</p> <p>4.The Maintenance Director/Designee will make rounds daily x 4 weeks then weekly x 4 weeks then monthly for at least 6 months to ensure that all doors close and latch into the door frame. The Maintenance Director/Designee will also complete rounds to ensure all penetrations are sealed with fire caulk daily x 4 weeks then weekly x 4 weeks then monthly for at least 6 months. The Executive Director will</p>	

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K 0062 SS=F Bldg. 01	<p>the ceiling of the laundry room behind the fuel fired dryers there was an unsealed half inch penetration around a pipe. Based on interview at the time of observation, the Environmental Supervisor acknowledged and provided the measurement of the penetration.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review and interview, the facility failed to ensure 1 of 1 sprinkler systems were maintained in proper working order. Once obstructive material is observed during an investigation as described in NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems at 10-2.1., NFPA 25, 10-2.3 requires a complete flushing program shall be conducted. The work shall be done by qualified personnel. This deficient practice affects all residents.</p> <p>Findings include:</p>			K 0062	<p>monitor that rounds are completed and that all ceiling penetrations are sealed daily x 4 weeks then weekly x 4 weeks then monthly for at least 6 months. The results of the monitoring will be forwarded to the CQI committee. 5.Completion date: 8-10-16 REQUESTING DESK REVIEW</p> <p>1. There were no residents affected by this practice. The pipes have been scheduled to be flushed per internal pipe inspection recommendations. Flush to be completed by September 30, 2016. ED reviewed inspections to ensure sprinkler inspections were current at this time. Sprinklers in the laundry room were immediately cleaned to ensure reliable operating condition. 2. All residents have the potential to be affected by this practice. All pipes have been scheduled to be flushed per recommendations to ensure free of foreign materials. Rounds were completed by the</p>		08/12/2016

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	<p>Based on records review of the internal pipe inspection with the Environmental Supervisor on 08/03/16 at 9:47 a.m., the "Report of Internal Condition of Sprinkler Piping" that was conducted on 09/10/15 by Dalmatian Fire INC stated "The Sprinkler System is in need of internal cleaning. Some of the pipes were found to be partially full of foreign materials." Based on an interview at the time of record review, the Environmental Supervisor stated there has not been a flush on the systems since the last internal pipe inspection.</p> <p>3.1-19(b) 2. Based on record review and interview, the facility failed to ensure sprinkler water-flow alarm devices were tested quarterly for 2 of 4 quarters. LSC 9.7.5 refers to NFPA 25, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, at 2-3.3 requires water-flow alarm devices and pressure switches that provide audible or visual signals to be tested quarterly. This deficient practice affects all occupants.</p> <p>Findings include: Based on records review of the quarterly sprinkler inspection documentation with</p>		<p>Maintenance Director to ensure all sprinklers are in reliable operating condition. 3.The Maintenance Director was educated by the Executive Director on 8-3-16 related to K062 to ensure all recommendations from inspections are followed and completed. Any recommendations made from inspectors will be reviewed by the ED to ensure completion and overseen by the Maintenance Director. The Maintenance Director was educated by the Executive Director on 8-3-16 related to K062 to ensure all automatic sprinklersystems are continuously maintained in reliable operating condition and are inspected and tested quarterly per K062. 4.The Maintenance Director/ Designee will review inspections with ED weekly x 4 weeks then bi weekly x 2 months then monthly for at least 6 months to ensure all recommendations have been completed and that sprinkler inspections have been completed per schedule. The Maintenance Director/ Designee will make rounds daily x 4 weeks then weekly x 4 weeks then monthly for at least 6 monthsto ensure all sprinkler systems are continuously maintained in reliableoperating condition. The results of the monitoring will be forwarded to the CQI committee. 5.Completion Date: 8-12-16</p>	

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	<p>Environmental Supervisor on 08/03/16 at 9:40 a.m., the facility lacked documentation of a sprinkler inspection where the water-flow alarms were tested for the first of 2016 and the third quarter of 2015. Based on an interview at the time of record review, the Environmental Supervisor was unable to provide any documentation for a 2016 first and 2015 third quarter sprinkler inspection.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to clean and maintain 12 of 12 sprinklers in the laundry room. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. This deficient practice can affect up to 5 residents outside the laundry.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Environmental Supervisor on 08/03/16 at 10:25 a.m., 12 automatic sprinklers in the laundry room where completely covered with dust and lint. Based on interview, this was acknowledged by the Environmental</p>		REQUESTING DESK REVIEW	

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K 0066 SS=F Bldg. 01	<p>Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 area where smoking was permitted for staff and residents was maintained. This deficient practice could affect up to all residents that enter the court yard.</p>	K 0066	<p>1. There were no residents affected by this practice. The trash can located in the in the smoking area by the dumpster and in the courtyard have been removed. Ash trays of noncombustible material and safe design are available in the smoking area per K066.</p>	08/10/2016	

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K 0147 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Environmental Supervisor on 08/03/16 at 11:37 a.m. and at 12:20 p.m., both the staff designated smoking area outside by the dumpsters and the resident smoking area in the court yard contained a plastic trash can with 10 to 20 cigarette butts mixed with combustible trash. Based on interview, this was acknowledged by the Environmental Supervisor at the time of observations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords in room 230 were not used as a substitute for fixed wiring to provide power for medical equipment. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National</p>	K 0147	<p>2.All residents have the potential to be affected by this practice. The Executive Director reviewed the location of all smoking areas to ensure no trash cans were present and that ashtrays of noncombustible material and safe design is available in the smoking area per K066.</p> <p>3.The staff has been educated by the Executive Director on 8-10-16 regarding K066 to ensure that all smoking materials are discarded in compliance with K066 in a noncombustible ashtray.</p> <p>4.The Maintenance Director/Designee will make rounds daily x 4 weeks then weekly x 4 weeks then monthly for at least 6 months to ensure all cigarette butts are disposed of in a safe manner per K062. The results of the monitoring will be forwarded to the CQI committee.</p> <p>5.Completion Date: 8-10-16 REQUESTING DESK REVIEW</p> <p>1.There were no residents affected by this practice. The power strip was replaced with a medical grade power strip.</p> <p>2.All residents have the potential to be affected by this practice. A house wide audit was completed by the Maintenance</p>	08/10/2016	

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	<p>Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 2 residents in room 230.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Environmental Supervisor on 08/03/16 at 11:03 a.m., an oxygen concentrator and an IV pump were supplied with electricity by standard extension cord power strip. Based on interview, this was acknowledged by the Environmental Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p>Director to ensure compliance with K147.</p> <p>3.The Maintenance Director and staff were educated on K147 by the Executive Director on 8-3-16.</p> <p>4.The Maintenance Director/Designee will make rounds daily x 4 weeks then weekly x 4 weeks then monthly for at least 6 months to ensure compliance with K147. The results of this monitoring will be forwarded to the CQI committee.</p> <p>5.Completion Date: 8-10-16 REQUESTING DESK REVIEW</p>		