

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  05/25/2016
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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 the Investigation of Complaints IN00200211, IN00200244, IN00200335, and IN00201138.</p> <p>Complaint IN00200211 Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00200244 Substantiated. Deficiencies related to the allegation are cited at F465.</p> <p>Complaint IN00200335 Substantiated. Deficiencies related to the allegation are cited at F323.</p> <p>Complaint IN00201138 Substantiated. Deficiencies related to the allegation are cited at F323 and F465.</p> <p>Survey dates: May 23, 24, and 25, 2016</p> <p>Facility number : 000092 Provider number: 155176 AIM number: 100266090</p> <p>Census bed type: SNF/NF: 73 Total: 73</p>	F 0000		
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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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F 0323 SS=D Bldg. 00	<p>Census payor type: Medicare: 7 Medicaid: 53 Other: 13 Total: 73</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure windows in good repair to prevent striking a resident for 1 of 3 residents reviewed with windows in poor repair. (Resident #W)</p> <p>Findings include:  During an environmental tour on</p>	F 0323	<p>F 323</p> <p>1. The identified window was fixed immediately in the presence of the surveyor. 2. All windows in the facility were reviewed on May 25th with no other issues noted. 3. The staff was educated that any windows noted to have a disconnected chain should be reported to the Maintenance Director and a work order completed, this will be conducted</p>	06/01/2016	

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	<p>5-23-2016 at 9:10 AM, in room 205, the widow sill was observed to have broken off in an area appropriately 5 inches long.</p> <p>In an interview on 5-23-2016 at 9:10 AM, the Maintenance Director indicated he had been off work recently, but the the windows and sashes had all been reviewed, and this was a new area. He further indicated he had not had time to look at his work orders for the day, and that he was unaware for the need for a new window sill.</p> <p>In an interview on 5-23-2016 at 1:22 PM, the Maintenance Director indicated he had replaced the sill and had not looked for a work order.</p> <p>During an environmental tour on 5-24-2016 at 9:18 AM, in room 107, the chain securing the bottom portion of the tip out window was observed to have become disconnected. The bottom portion of the window could tip into the resident room approximately 10 inches past the window sill, if the locks on the top of this portion of the window were pushed in to allow the window to release. The window opened and closed without sticking.</p> <p>In an interview on 5-24-2016 at 9:18 AM, the Maintenance Director indicated</p>		<p>by the Director of Nursing or designee by June 1st.</p> <p>4. The Maintenance Director or designee will monitor, using a monthly preventative maintenance assignment for compliance weekly for 2 weeks, then Monthly for 6 months, then quarterly for 6 months and forward results to monthly CQI committee for review. If any findings are out of compliance, then additional monitoring and an additional action plan will continue as determined by the committee. Compliance threshold is 100%. Systems will be implemented by June 1st</p>	

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	<p>he had not seen a work order for the window chain, therefore it must have become disconnected recently, and fixed the chain immediately.</p> <p>Resident #W's record was reviewed on 5-24-2016 at 10:23 AM. Resident #W's diagnoses included, but were not limited to, diabetes, high blood pressure, and kidney failure.</p> <p>A review of Resident #W's event dated 5-12-2016 at 11:18 PM indicated Resident #W was "hit on the right side of the face with the window"</p> <p>A review of Resident #W's progress notes dated 5-12-2016 at 11:28 PM indicated " Resident was in bed with window cracked open, the chain broke, and hit resident in the right side of the face. Ice pack was applied to face."</p> <p>A review of Resident #W's progress notes dated 5-13-2016 at 11:00 AM indicated "there were no discolorations to Resident #W's skin."</p> <p>In an interview on 5-23-2016 at 1:28 PM LPN #1 indicated "We didn't know the window was broken. We are supposed to file a work order when something is broken, but we have not had someone consistently when our Maintenance guy</p>			

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F 0465 SS=E Bldg. 00	<p>was off sick."</p> <p>This Federal Tag is related to Complaints IN00200335, and IN00201138.</p> <p>3.1-45(a)(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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure walls and doors in good repair in 13 of 45 rooms, this had the potential to affect 22 residents; the facility further failed to ensure toilets and bathrooms were kept free of brown smears in 3 of 45 rooms, this had the potential to affect 6 residents; Additionally, the facility failed to ensure electrical outlets were properly maintained in 3 of 45 rooms, this had the potential to affect 4 residents; the facility failed to ensure portable oxygen tanks were clean for 1 of 1 residents reviewed with portable oxygen tanks; and the</p>	F 0465	<p>F 465</p> <p>1.All identified areas of concern noted on surveydocument 2567 were addressed prior to the surveyors exit on May 25th.</p> <p>2.All privacy curtains will be taken down andwashed. All toilets were inspected and cleaned as needed. All walls and doorswere inspected and placed on a priority list to be addressed. Door and roomrenovations were previously initiated (see attached contractor approved bid)and will continue until completed. All electrical outlets in the facility werereviewed by an electrician on 5/28/2016 for proper function and replaced asneeded (see attached invoice). All portable oxygen</p>	06/01/2016			

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	<p>facility failed to ensure clean air conditioners in 7 of 45 rooms, this had the potential to affect 14 residents; also, the facility failed to ensure baseboard heaters were clean and in good repair in 6 of 45 rooms, this had the potential to affect 9 residents; finally, the facility failed to maintain clean privacy curtains in 13 of 45 rooms, this had the potential to affect 25 residents.</p> <p>Findings include:</p> <p>1. On an environmental tour on 5-23-2016 at 9:10 AM, the following was observed: In room 215, a 4 inch x 2 inch hole in the wall behind the second bed. In room 210, the kydex on the bathroom door was broken and sharp. In room 205, a 5 inch x 2 inch scrape about 24 inches from the floor. In room 202, the bathroom door was scraped 1 inch x 8 inches about 24 inches from the floor, additionally, the kydex on the door was broken, and pulled away from the door. In room 201, in the bathroom between the toilet and the sink, was a hole about 2 inches in diameter where the assist bar had been located. In room 111, in the bathroom between the toilet and the sink, was a hole about 2 inches in diameter where the assist bar</p>		<p>tanks were cleaned on 5/25/2016. All air conditioners and base board heaters were cleaned on 5/25/2016. An order of 30 new air conditioners was placed on 5/27 to replace older style units in the facility.</p> <p>3. The staff was educated that any repairs in rooms noted should be reported to the Maintenance Director and a work order completed, this will be conducted by the Director of Nursing or designee by June 7th. The Environmental Service Director was also educated to complete weekly rounds of rooms and inspection of facility cleanliness to ensure compliance in identified areas by the Executive Director by June 1st</p> <p>4. The Maintenance Director or designee will monitor compliance room inspection checklist for compliance weekly of 20 rooms for 2 weeks, then weekly of 10 rooms for 6 months and forward results to monthly CQI committee for review. If any findings are out of compliance, then additional monitoring and an additional action plan will continue as determined by the committee. Compliance threshold is 100%.</p> <p>5. Systems will be implemented by June 1st, 2016</p>	

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	<p>had been located.</p> <p>In room 109, a 48 inch x 12 inch hole behind the toilet around the valve and up the wall. The cove base was pulled away from the length of the wall behind the toilet.</p> <p>In room 107, in the bathroom between the toilet and the sink, was a hole about 2 inches in diameter where the assist bar had been located.</p> <p>In room 104, the wall behind the lounge chair was scarred 1/4 inch x 3 inches in 5 areas. The wall corner by the bathroom by the floor was without drywall, and the wood underneath could be seen in an area about 10 inches x 2 inches. Further, there was an area about 6 inches x 6 inches scarred by the first bed. In the bathroom between the toilet and the sink, there was also a hole about 2 inches in diameter where the assist bar had been located.</p> <p>In room 101, in the bathroom between the toilet and the sink, was a hole about 2 inches in diameter where the assist bar had been located.</p> <p>In room 220, there was an area about 12 inches x 2 inches scarred down into the drywall by the bathroom door bottom. Further, the kydex on the bathroom door is pulled back and broken in an area about 4 inches x 5 inches.</p> <p>In room 228, in the bathroom between the toilet and the sink, was a hole about 2 inches in diameter where the assist bar</p>			

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	<p>had been located. Further, there was an area about 2 inches x 6 inches behind the toilet.</p> <p>In room 231, in the bathroom between the toilet and the sink, was a hole about 2 inches in diameter where the assist bar had been located. Further, there was a scar down into the wood on the bathroom door about 1 inch x 3 inches.</p> <p>2. On the environmental tour on 5-23-2016 at 9:10 AM, the following was observed:</p> <p>In room 215, there were brown smears on the toilet.</p> <p>In room 205, there were brown flecks in the corner behind the toilet.</p> <p>In room 103, there was brown smear on the floor by the toilet.</p> <p>In room 228, a broken outlet by the air conditioner.</p> <p>In room 301, the outlet on the wall was loose.</p> <p>In room 231, the overbed light on the first bed was loose and wobbly on the wall.</p> <p>4. During an environmental tour on 5-24-2016 at 9:18 AM, the following was observed:</p> <p>In room 302, the portable oxygen tank had flecks of white and gray around the edges and amount indicator.</p> <p>In room 306, the room air conditioner</p>			

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	<p>had black round spots in the vents that could be scraped off.</p> <p>In room 216, the air conditioner cord was blackened, and dirty. The front of the air conditioner was dirty and had black spots in the vents.</p> <p>In room 208, the air conditioner had black spots in the vents.</p> <p>In room 107, the air conditioning unit had black spots on the vents.</p> <p>In room 106, the air conditioner had black spots in the vents.</p> <p>In room 103, the air conditioner had black dust and spots in the vents.</p> <p>In room 101, the air conditioner had no cover on the front.</p> <p>6. During an environmental tour on 5-23-2016 at 9:10 AM, the following was observed:</p> <p>In room 206, the baseboard heating unit was broken with the sharp edge sticking out about 2 inches.</p> <p>During an environmental tour on 5-24-2016 at 9:18 AM, the following was observed:</p> <p>In room 307, the baseboard heating unit was coming away from the wall.</p> <p>In room 231, the heating unit cover was loose.</p> <p>In room 226, the heating unit was rusty and dirty over the top.</p> <p>In room 212, the heating unit was loose from the wall and wobbly.</p>			

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	<p>In room 106, the baseboard heating unit had large area of peeling paint, and back dust covering the top.</p> <p>7. During an environmental tour on 5-24-2016 at 9:18 AM, the following was observed:</p> <p>In room 308, the privacy curtains had numerous brown spots.</p> <p>In room 312, all three privacy curtains had brown stains and splashes.</p> <p>In room 227, two of the privacy curtains had brown spots.</p> <p>In room 231, the privacy curtain between the beds had a crusty green hard substance on it in various spots.</p> <p>In room 230, the privacy curtains had brown spots.</p> <p>In room 226, both privacy curtains had yellow spots on them.</p> <p>In room 224, the privacy curtain between the beds had mesh ripped at the top about 5 inches in diameter</p> <p>In room 222, the privacy curtains had brown spots on them.</p> <p>In room 215, the privacy curtain had about a 4 inch rip in the bottom of the curtain.</p> <p>In room 208, the privacy curtain was stained brown in numerous places.</p> <p>In room 202, the privacy curtain had yellow spots on it in numerous places.</p> <p>In room 106, all three privacy curtains had yellow spots, green hard substances,</p>			

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	<p>and brown spots on them in numerous places.</p> <p>In room 101, the privacy curtains were not able to be moved around the track to protect the resident from view.</p> <p>In an interview on 5-24-2016 at 10:22 AM, the Director of Maintenance indicated he had been off work approximately 3 months, and although the facility had stand in maintenance workers, some items were missed.</p> <p>A review of the facility maintenance action plan provided by the Administrator on 5-24-2016 at 9:10 AM, indicated the facility was renovating bathrooms, and rooms, and maintenance was being reviewed to prioritize work orders and maintenance requests.</p> <p>This Federal Tag is related to Complaints IN200244, and IN00201138.</p> <p>3.1-19(f)</p>			