

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 01/29/2014
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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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K010000	<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: 01/29/14</p> <p>Facility Number: 000092 Provider Number: 155176 AIM Number: 100266090</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Glenbrook Rehabilitation & 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 in</p>	K010000	<p>Glenbrook Rehabilitation and Skilled Nursing Center is requesting a desk review of the submitted plan of correction. We have attached documents supporting the identified CQI tools, trainings, and audits to be utilized in correcting the cited items. If you have further questions please contact Gregg Fuller Executive Director. We thank you for your consideration in this matter</p>	
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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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	<p>areas open to the corridors. Battery operated smoke detectors have been installed in the resident rooms. The facility has a capacity of 90 and had a census of 72 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 by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/06/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 8 resident room corridor doors in the northwest 200 hall closed and latched into the door frame. This deficient practice could affect residents in 1 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 01/29/14 at 12:35 p.m., the corridor door to resident room 222 failed to latch into the door frame. Based on an interview with the Maintenance Supervisor at the time of observation, he stated a new striker plate was needed.</p>	K010018	<ol style="list-style-type: none"> The resident room door had a new strike plate placed. All corridor doors have been reviewed for appropriate latching doors by the maintenance director. All residents have the potential to be affected. The Maintenance Director was educated by the Executive Director on 2/7/14 that all doors installed in corridor spaces will latch into their frame. The Maintenance Director will check corridors monthly that positive latching hardware is in place and latching properly. Maintenance Director will report findings to CQI committee for appropriate follow up for at least 6 months. If 100% threshold is not met and action plan will be developed 	02/14/2014			

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K010021 SS=E	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 single smoke barrier doors would close upon activation of the fire alarm system. This deficient practice could affect residents in 2 of 6 smoke compartments.</p> <p>Finding include: Based on observation with the</p>	K010021	<p>1. The identified corridor door was closed to ensure proper function by removing the door stop. 2. All corridor exits were reviewed for proper function. All residents have the potential to be affected. 3. The Maintenance Director was educated by the Executive Director on 2/5/14 that all exit doors need to be left in proper working order. The Maintenance will monitor the door on his daily rounds. 4. The</p>	02/14/2014

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K010038 SS=E	<p>Maintenance Supervisor on 01/29/13 at 1:30 p.m., the smoke barrier door located in the service hall was propped open with a wooden door wedge. Based on an interview with the Maintenance Supervisor at the time of observation, he put the door wedge in place earlier that morning to move supplies and forgot to remove it when called for another task.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 corridor doors from the therapy room was provided with door latches readily operated under all lighting conditions. LSC 7.2.1.5.4. requires where a latch or other similar device is provided, the method of operation of its releasing device must be obvious, even in the dark. The intention of this requirement is the method of release be one which is familiar to the average person. For example, a two step release, such as a knob and independent dead bolt, is not acceptable. In most occupancies, it is important a single action unlatch the door. This deficient practice could affect 8 residents in the therapy room.</p>	K010038	<p>maintenance director will monitor 5 times per week for proper closure for at least 6 months. Maintenance Director will report findings to CQI committee for appropriate follow up. If 100% threshold is not met and action plan will be developed.</p> <p>1. The therapy door has had a single handle lock system placed and the dead bolt removed. 2. All corridor doors have been reviewed by the maintenance director for appropriate latching doors. All residents have the potential to be affected. 3. The Maintenance Director was educated by the Executive Director on 2/7/14 that all doors installed in corridor spaces will have single motion lock/latching systems. 4. The Maintenance Director will check corridors monthly that positive latching hardware is in place and latching properly. Maintenance Director will report findings to CQI committee for appropriate follow up for at least 6 months. If 100% threshold is not met and action</p>	02/14/2014			

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K010044 SS=E	<p>Findings include:</p> <p>Based on observation with Maintenance Supervisor on 01/29/14 at 11:50 a.m., the therapy room corridor door was equipped with an independent dead bolt in addition to the door knob. The Maintenance Supervisor acknowledged the therapy room had an independent dead bolt at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 fire door sets was arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. This</p>	K010044	<p>plan will be developed.</p> <p>1. The fire door has been fixed to latch properly. 2. All corridor fire doors have been reviewed for appropriate latching doors. All residents have the potential to be affected. 3. The Maintenance Director was educated by the Executive Director on 2/7/14 that all fire doors installed in corridor spaces will have working latching systems. 4. The Maintenance Director will check corridors monthly that positive latching hardware is in place and latching properly. This will also be reviewed during routine fire drills. Maintenance Director will report</p>	02/14/2014			

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	<p>deficient practice could affect 2 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation Maintenance Supervisor on 01/29/14 at 12:18 p.m., the fire door set near resident room 312 failed to latch into the frame when tested manually. Based on an interview with the Maintenance Supervisor at the time of observation, the doors were recently painted and paint on the hinges of the fire doors preventing the doors from latching.</p> <p>3.1-19(b)</p>		findings to CQI committee for appropriate follow up for at least 6 months. If 100% threshold is not met and action plan will be developed.				
K010046 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 battery powered emergency lighting fixtures in the basement would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This</p>	K010046	<p>1. The identified battery powered emergency light has a new battery placed.2. All battery powered lights were reviewed in the facility by the maintenance director. All residents have the potential to be affected. 3. The Maintenance Director was educated by the</p>	02/14/2014			

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K010147 SS=D	<p>deficient practice was not in a resident care area but could affect staff.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Supervisor on 01/29/14 at 1:55 p.m., the battery operated emergency light in the basement water heater room failed to illuminate when tested. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 4 of 4 flexible cords were not used as a substitute for fixed wiring to provide power for medical equipment or equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice was not in a resident care area but could affect facility staff.</p>	K010147	<p>Executive Director on 2/7/14 that battery operated emergency lights need checked routinely for proper function.4. The identified lights will be reviewed monthly on routine inspections. Maintenance Director will report findings to CQI committee for appropriate follow up for at least 6 months. If 100% threshold is not met and action plan will be developed.</p> <p>1. The identified power strips were removed 2. All remaining offices were inspected for proper electrical plugs. All residents have the potential to be affected. 3. The Management Team was educated by the Executive Director on 2/7/14 that all high current draw devices need to be placed into wall outlets. 4. During monthly inspections the Director will ensure proper plugs are being used. Maintenance Director will report findings to CQI committee for appropriate follow up for at least 6 months. If 100% threshold is not met and action plan will be</p>	02/14/2014			

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	<p>Findings include:</p> <p>Based on observation and interview with the Maintenance Supervisor on 01/29/14 from 11:55 a.m. to 2:30 p.m., he acknowledged the following areas had high current draw equipment supplied electricity by an extension cord power strip:</p> <ul style="list-style-type: none"> a. a microwave in the Business office. b. a refrigerator and a microwave in the conference room c. a refrigerator in the Medical Records/ADNS office d. a coffee maker and a toaster in the Maintenance shop <p>3.1-19(b)</p>		developed.	
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