

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  12/09/2014
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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: 12/10/14</p> <p>Facility Number: 000092 Provider Number: 155176 AIM Number: 100266090</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist; Thomas Forbes, Life Safety Code Specialist</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</p>	K010000		
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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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K010038 SS=E	<p>areas open to the corridors. Battery operated smoke detectors have been installed in the resident rooms. The facility has a capacity of 82 and had a census of 71 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 Dennis Austill, Life Safety Code Specialist on 12/16/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</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 4 of 7 exit doors were accessible. Health care occupancies permit delayed-egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(c) requires an irreversible process shall release the lock within 15 seconds upon application of a force to the release device. This deficient</p>	K010038	<p>1.The identified exit doors have had the releasetimes adjusted by Vanguard.</p> <p>2.All exit doors have been reviewed by Vanguardfor appropriate timed release. All residents have the potential to be affected.</p> <p>3.The Maintenance Director was educated by theExecutive Director on 12/19/14 that all doors installed as exit will have arelease</p>	12/29/2014	

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K010064 SS=E	<p>practice could affect 13 residents in the 300 hall; 19 residents in the 200 south hall; 10 ten residents in the Apple Blossom lounge; and any number of staff and residents in the Administration hall.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Supervisor on 12/10/14 between 11:45 a.m. and 12:30 p.m., the 300 hall north exit door, 200 south hall exit door, Apple Blossom lounge exit door, and the administration north hall exit door, which were equipped with electromagnetic locks, would not release after pushing the door for 15 seconds. When tested by the Maintenance Director at the time of observations, he acknowledged the doors would not release after 15 seconds, unless he made adjustments for them to work.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler riser room portable fire extinguishers was mounted so the bottom of the</p>	K010064	<p>time of 15 seconds.</p> <p>4. The Maintenance Director will check exits monthly with the fire drill that exit doors release in 15 seconds. 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>5. December 29th 2014</p> <p>1. The identified corridor fire extinguisher was mounted per regulation.</p> <p>2. All fire extinguishers were reviewed for proper mounting. All</p>	12/29/2014			

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K010066 SS=E	<p>extinguisher was no less than four inches above the floor. NFPA 10, Section 1-6.10 requires fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so that the top of the fire extinguisher is not more than 5 feet (60 inches) above the floor and no less than 4 inches from the floor. This deficient practice could affect 13 residents on the 300 hall in the event of an emergency requiring evacuation through the 300 exit door.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Supervisor on 11/10/14 at 11:50 a.m., the fire extinguisher was not mounted on the wall and was sitting on the floor in the sprinkler riser room. The Environmental Supervisor acknowledged that the fire extinguisher was sitting on the floor.</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</p>		<p>residents have the potential to be affected</p> <p>3. The Maintenance Director was educated by the Executive Director on 12/19/14 that all fire extinguishers need to be mounted per NFPA guidelines. The Maintenance will monitor the location of the fire extinguishers on his daily rounds.</p> <p>4. The maintenance director will monitor weekly for proper mounting 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>5. December 29th 2014</p>	

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	<p>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 observations and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container which was provided for 2 of 2 areas where smoking was permitted. This deficient practice could affect 10 residents in the courtyard and visitors and staff if they were utilizing the Employee Service hall exit during a fire emergency.</p> <p>Findings include:</p> <p>Based on observations with the Environmental Supervisor on 12/10/14 at 12:45 p.m., the smoking area twenty feet outside of the Employee Service hall exit had 25 cigarette butts strewn about the staff seating area in dried leaves. Furthermore, both the staff and residents's smoking areas had 10 cigarette butts that was observed in a trash container which was full of paper goods</p>	K010066	<p>1.The smoking areas were cleaned of cigarettebutts.</p> <p>2.All entries and smoking areas were reviewed forbutts and are was cleaned. All residents have the potential to be affected.</p> <p>3.Staff and residents have been educated by themanagement team as to the proper disposal of cigarette butts on December 22nd.</p> <p>4.The Maintenance Director will check smokingareas 5 times per week for proper placement of cigarette butts. Maintenance Director will report findings toCQI committee for appropriate follow up for at least 6 months. If 100%threshold is not met and action plan will be developed.</p> <p>5.December 29th 2014</p>	12/29/2014

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K010076 SS=E	<p>and products. Based on interview, the Environmental Supervisor acknowledged the facility's employees disposed of cigarette butts on the ground, and that both staff and residents smoking areas had cigarette butts disposed into a container full of paper products instead of using the approved long neck vessel which was provided.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 2 of 6 cylinders of nonflammable gases such as oxygen were properly chained or supported in a proper cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder</p>	K010076	<p>1.The identified oxygen tanks were supported asrequired.</p> <p>2.All gas cylinders were reviewed for properstorage. All residents have the potential to be affected.</p> <p>3.The Maintenance Director and nursing staff wereeducated by the Executive Director on 12/19/14 that all gas cylinder tanks willbe properly chained or supported.</p>	12/29/2014

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K010147 SS=D	<p>stand or cart. This deficient practice could affect 27 residents in the 100 hall and 200 south hall.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Supervisor on 12/10/14 at 12:25 p.m., two oxygen cylinders were standing in the oxygen supply room without support. The Environmental Supervisor agreed at the time of observation, the cylinders should have been secured.</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>1. Based on observation and interview, the facility failed to ensure 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 that, 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>4. The Maintenance Director will check gascylinders weekly for proper storage. Maintenance Director will report findings toCQI committee for appropriate follow up for at least 6 months. If 100%threshold is not met and action plan will be developed.</p> <p>5. December 29th 2014</p> <p>1. The identified power strip and extension cord wereremoved and the GFCI plug identified was installed.</p> <p>2. All remaining offices and rooms with runningwater were inspected for proper electrical plugs. All residents have the potential to beaffected.</p> <p>3. The Management Team was educated by theExecutive Director on 12/19/14 that all high current draw devices need to beplaced into wall outlets and that the use of extension cords is not permittedand that wet areas need a GFCI plug.</p>	12/29/2014	

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	<p>Findings include:</p> <p>Based on observation and interview with the Environmental Supervisor on 12/10/14 at 11:45 a.m., he acknowledged that monitoring equipment was supplied electricity by an power strip, plugged in to an extension cord, plugged into another power strip. This was located in the Administrator Office's closet.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 wet location in the soiled side of the laundry room was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas that are subject to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and</p>		<p>4. During monthly inspections the Maintenance Director will ensure proper plugs are being used and that proper GFCI are properly installed and operating. 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>5. December 29th 2014</p>	

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	<p>electrical insulation is more subject to failure. This deficient practice could affect all, staff and visitors in the laundry areas.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Supervisor during the on 12/10/14 at 1:00 p.m., an electric receptacle was on the wall within three feet of the utility sink in the soiled laundry room. Based on interview and testing with the Environmental Supervisor at the time of observation, neither the electrical outlets nor the circuit breakers for these outlets were provided with GFCI protection.</p> <p>3.1-19(b)</p>			