STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155176	A. BUILDING -- B. WING	11/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLENBROOK REHABILITATION & SKILLED NURSING CENTER	3811 PARNELL AVE FORT WAYNE, IN 46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/06/22 Facility Number: 000092 Provider Number: 155176 AIM Number: 100266090 At this Emergency Preparedness survey, Glenbrook Rehabilitation and Skilled Nursing Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 82 and had a census of 54 at the time of this survey. Quality Review completed on 11/09/23	E 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a post survey revisit on or after December 22, 2023.	
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(EP Training Program Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR	E 0037	-What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were negatively affected. New employees will be trained on emergency preparedness upon their orientation period. Existing employees will be trained annually. -How other residents having the	12/08/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christopher Adams	HFA	11/24/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	483.73(d) (1). This deficient practice could affect all residents in the facility. Findings include: Based on records review with the Facilities Manager, the Director of Property Management, and the Maintenance Director on 11/06/23 at 10:48 a.m., no documentation of annual EEP training and no documentation to show staff could demonstrate knowledge of the EPP was available for review. Based on an interview at the time of records review, the Facilities Manager stated the EPP training was conducted within the last year but was unable to access the training documentation on the Relias electronic training system. The finding was reviewed with the Facilities Manager, the Director of Property Management, and the Maintenance Director at the exit conference.		potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. We will train all new employees upon their orientation period. New employees will be trained annually. All employees will be subject to a questionnaire on emergency preparedness. -What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director has been delegated to lead the emergency preparedness training for new and existing employees. The Administrator will review this annually with the Maintenance Director. -How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. What quality assurance program will be put into place: The emergency preparedness training will be added to TELS as a recurring annual task. Administrator will be monitoring to ensure new employees are receiving their emergency preparedness training. IDT will review training program monthly at	

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			QA meeting.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to conduct exercises to test the emergency preparedness plan (EPP) at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This	E 0039	-What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were negatively affected by the alleged deficient practice. -How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. The facility had an emergency event on 10/12/23, however, upon survey, full documentation was not accessible. The facility will submit analyzation of emergency event. A tabletop exercise will be completed with changes made to applicable polices, as needed. -What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director has been delegated to lead a tabletop exercise annually. ED/Designee to coordinate or attend a	12/08/2023

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	deficient practice could affect all occupants. Findings include: Based on review of the facility's EPP with the Facilities Manager, the Director of Property Management, on 11/06/23 at 1:10 p.m.: A.) There was documentation of an actual emergency event on 10/12/23 but there was no documentation that analyzed the facility's response and revised the facility's emergency plan if needed. B.) No documentation of a second exercise of choice was available for review. Based on interview at the time of records review, the Facilities Manager agreed no paperwork was available to show a the facility analyzed the response of the actual emergency event and no documentation could be found of a conducted second exercise of choice. The finding was reviewed with the Facilities Manager, the Director of Property Management, and the Maintenance Director at the exit conference.		community emergency preparedness event annually if actual emergency event does not occur. -How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. What quality assurance program will be put into place: Emergency preparedness exercises will be reviewed at QA meeting 6 months after the last exercise to ensure requirements have been met annually. If 100% compliance is not achieved, an action plan will be put into place by ED/Designee.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/06/23 Facility Number: 000092 Provider Number: 155176 AIM Number: 100266090	K 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a post survey	

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	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 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. 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 facility has a capacity of 82 and had a census of 54 at the time of this survey. All areas where the residents have customary access are sprinkered. All areas providing facility services are sprinklered. Quality Review completed on 11/09/23		revisit on or after December 22, 2023.	
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review, observation, and interview, the facility failed to maintain 1 of 1 automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all 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. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance	K 0353	-What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were negatively affected by the alleged deficient practice. -How other residents having the potential to be affected by the same deficient practice will be	12/22/2023

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	required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on records review of Fire Sprinkler System Inspection documentation dated 08/09/23 with the Facilities Manager, the Director of Property Management, and the Maintenance Director on 11/06/23 at 10:18 a.m., the deficiencies section stated over 30 sprinkler heads throughout the building were loaded or covered with paint. There was documentation stating parts are on order and work on the sprinkler heads should begin in the end of November. Based on observation between 11:00 a.m. and 1:00 p.m., about a quarter of sprinkler heads in the building had signs of paint, and in the attic about a quarter of sprinkler heads were loaded with insulation. Based on interview at the time of record review, the Director of Property Management stated the facility is aware of the issue and is waiting on parts to complete the repairs. The finding was reviewed with the Facilities Manager, the Director of Property Management, and the Maintenance Director at the exit conference. 3.1-19(b)		identified and what corrective action(s) will be taken: All residents have the potential to be affected. Facility contacted IEI to service sprinkler heads in attic space. Loaded sprinkler heads in other areas of facility have been repaired. -What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director will check sprinkler heads in attic space at least monthly. -How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. What quality assurance program will be put into place: Sprinkler head checks will be conducted by Maintenance Director/Designee weekly x 4 weeks and then monthly thereafter to ensure sprinkler heads are not loaded. IDT will review any negative findings at the monthly QA meeting and an action plan will be put into place with any negative findings.	
K 0712 SS=C	NFPA 101 Fire Drills			

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Bldg. 01	Based on records review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on second shift for 4 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on records review with the Facilities Manager, the Director of Property Management, and the Maintenance Director on 11/06/23 at 10:00 a.m., all second shift (2:00 p.m. to 10:00 p.m.) fire drills took place at between 3:00 p.m. and 4:15 p.m. This condition does not allow fire drills on second shift to be conducted at unexpected times. Based on interview at the time of records review, the Director of Property Management agreed all second shift fire drills were not conducted at unexpected times. The finding was reviewed with the Facilities Manager, the Director of Property Management, and the Maintenance Director at the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	-What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were negatively affected by the alleged deficient practice. -How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. Fire drills will be conducted at various, unexpected times by the Maintenance Director monthly. -What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: A schedule of various, unexpected fire drills will be built by Maintenance Director to ensure requirements are met monthly based upon previous months. -How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. What quality assurance program will be put into place: ED/Designee will review monthly	12/22/2023

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			fire drills with Maintenance Director by the 20th of every month to allow ample time to conduct additional drills if necessary. Findings will be reviewed at monthly QA meeting and any negative findings will negate an action plan.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 2 of 2 power cord daisy chains were not used as and as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. Article 400.8 (1) prohibits daisy chains, because the first extension cord (or power strip) is now acting as a substitute for the fixed wiring of a structure. This deficient practice could affect up to 15 residents in one smoke compartment. Findings include: Based on observation with the Facilities Manager, the Director of Property Management, and the Maintenance Director on 11/06/23 at 11:38 a.m., in the Business Office a power strip was plugged into and supplied power by another power strip. Based on interview at the time of observation, the Facilities Manager agreed a power strip was daisy chained to another power strip. The finding was reviewed with the Facilities Manager, the Director of Property Management, and the Maintenance Director at the exit conference.	K 0920	-What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were negatively affected by the alleged deficient practice. -How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Up to 15 residents in one smoke compartment could be affected. The daisy chained power strips were removed from Business Office and replaced with hospital grade surge protectors, each plugged into their own outlets. -What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:	11/25/2023

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	3.1-19(b)		Maintenance Director will conduct audits of rooms in facility to ensure the alleged deficient practice does not recur. -How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. What quality assurance program will be put into place: Maintenance Director/Designee will audit rooms in facility weekly x 4 weeks, monthly x 6 months, and quarterly until 100% compliance is maintained for 12 months. Results of audits will be reviewed at QA meeting monthly. If any negative findings, an action plan will be implemented.	