PRINTED: 09/23/2024

	T OF HEALTH AND H R MEDICARE & MEDI						RM APPROVED IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155176		A. B	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  11/06/2023		
	PROVIDER OR SUPPLII	ER ATION & SKILLED NURSING CEN	NTER	3811 F	ADDRESS, CITY, STATE, ZIP COD PARNELL AVE WAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
E 0000							
E 0037 SS=F	conducted by the accordance with 4 Survey Date: 11/4 Facility Number: Provider Number: AIM Number: 100 At this Emergency Glenbrook Rehab Center was found Emergency Prepa Medicare and Me and Suppliers, 42 capacity of 82 and of this survey.  Quality Review conductions of the survey o	2000092 155176 2266090 W Preparedness survey, ilitation and Skilled Nursing not in compliance with redness Requirements for dicaid Participating Providers CFR 483.73. The facility has a I had a census of 54 at the time	E 0	000	The creation and submission this plan of correction does not constitute an admission by the provider of any conclusion see in the statement of deficiencies of any violation of regulation. provider respectfully requests the 2567 Plan of Correction be considered the letter of credit allegation and requests a deserview in lieu of a post survey revisit on or after December 22023.	ot is t forth es, or This that e ole	
Bldg	Based on record refailed to conduct a Emergency Preparage facility must do altraining in emerge procedures to all reindividuals provide and volunteers, conductivity and volunteers, conductivity and record	eview and interview, the facility annual training for the redness Program (EPP). The LTC I of the following: (i) Initial ency preparedness policies and new and existing staff, ling services under arrangement, ensistent with their expected emergency preparedness	E 0	037	-What corrective action(s) will accomplished for those reside found to have been affected by deficient practice:  No residents were negatively affected. New employees will trained on emergency preparedness upon their orientation period. Existi	ents by the be	12/08/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

training at least annually; (iii) Maintain

documentation of all emergency preparedness

training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR

> TITLE (X6) DATE

employees will be trained

-How other residents having the

annually.

**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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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 11/06/2023			
NAME OF PROVIDER OR SUPPLIER GLENBROOK REHABILITATION & SKILLED NURSING CENTE			STREET ADDRESS, CITY, STATE, ZIP COD  3811 PARNELL AVE  FORT WAYNE, IN 46805					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	483.73(d) (1). This all residents in the f	deficient practice could affect acility.			potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:	;		
	Based on records re Manager, the Direct and the Maintenance a.m., no documentat no documentation to demonstrate knowle for review. Based o records review, the EPP training was co but was unable to a documentation on th system.  The finding was rev Manager, the Direct	edge of the EPP was available in an interview at the time of Facilities Manager stated the conducted within the last year			All residents have the potential be affected. We will train all numbers or employees upon their oriental period. New employees will be trained annually. All employees will be subject to a questionnation on emergency preparedness.  -What measures will be put in place or what systemic chang will be made to ensure that the deficient practice does not recommend to the emergency preparedness training of the monitored to ensure the deficient practice will review annually with the Maintenance Director.  -How the corrective action(s) be monitored to ensure the deficient practice will not recurring. What quality assurance program will be put into place.  The emergency preparedness training will be added to TELS a recurring annual task. Administrator will be monitoring ensure new employees are receiving their emergency preparedness training. IDT wireview training program montity review training program montity or ensure training program montity review tr	ew cion e e es aire nto es cur: s ning es. this e will r, : s as ag to		

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CENTERS FO	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155176		ì í	JILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/06/2023		
NAME OF PROVIDER OR SUPPLIER GLENBROOK REHABILITATION & SKILLED NURSING CEN			NTER	3811 P	ADDRESS, CITY, STATE, ZIP COD PARNELL AVE WAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
E 0039 SS=F Bldg	Based on record reversible to conduct expreparedness plan (including unannour emergency proceduthe following: (i) Participate in an is community-based a. When a communaccessible, conduct facility-based funct b. If the LTC facility or man-made emergency proceduthe emergency proceduthe following: (i) Participate in an is community-based function accessible, conduct facility-based function and the emergency procedure from engaging its in community-based of full-scale functional the onset of the activation (ii) Conduct an addinclude, but is not lated a. A second full-scale functional exercises b. A mock disaster c. A tabletop exercise.	eview and interview, the facility exercises to test the emergency (EPP) at least twice per year, unced staff drills using the dures. The LTC facility must do n annual full-scale exercise that ed; or mity-based exercise is not et an annual individual, etional exercise. But experiences an actual natural regency that requires activation plan, the LTC facility is exempt next required full-scale in a or individual, facility-based had exercise for 1 year following stual event. ditional exercise that may limited to the following: cale exercise that is or an individual, facility-based exercise or workshop that is led by a ludes a group discussion, using		039	-What corrective action(s) will accomplished for those resider found to have been affected by deficient practice:  No residents were negatively affected by the alleged deficier 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 be affected. The facility had an emergency event on 10/12/23, however, upon survey, full documentation was not accessible. The facility will sub analyzation of emergency event A tabletop exercise will be completed with changes made applicable polices, as needed.	action(s) will be those residents en affected by the ents having the fected by the ractice will be at corrective aken: e the potential to facility had an t on 10/12/23, urvey, full ras not facility will submit energency event. se will be	
	a narrated, clinicall and a set of probler messages, or prepar challenge an emerg (iii) Analyze the LT	y-relevant emergency scenario, n statements, directed red questions designed to			-What measures will be put in place or what systemic change will be made to ensure that the deficient practice does not reconstitute.	es e ur:	

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exercises, and emergency events, and revise the

LTC facility's emergency plan, as needed in

accordance with 42 CFR 483.73(d)(2). This

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been delegated to lead a tabletop

exercise annually. ED/Designee

to coordinate or attend a

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 155176 B. WING 11/06/2023

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP COD 3811 PARNELL AVE

GLENBR	OOK REHABILITATION & SKILLED NURSING CEN		3811 PARNELL AVE FORT WAYNE, IN 46805			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	· · · · · · · · · · · · · · · · · · ·	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE		
	deficient practice could affect all occupants.		community emergency			
			preparedness event annually if			
	Findings include:		actual emergency event does not			
			occur.			
	Based on review of the facility's EPP with the					
	Facilities Manager, the Director of Property		-How the corrective action(s) will			
	Management, on 11/06/23 at 1:10 p.m.:		be monitored to ensure the			
	A.) There was documentation of an actual		deficient practice will not recur,			
	emergency event on 10/12/23 but there was no		i.e. What quality assurance			
	documentation that analyzed the facility's		program will be put into place:			
	response and revised the facility's emergency plan					
	if needed.		Emergency preparedness			
	B.) No documentation of a second exercise of		exercises will be reviewed at QA			
	choice was available for review.		meeting 6 months after the last			
	Based on interview at the time of records review,		exercise to ensure requirements			
	the Facilities Manager agreed no paperwork was		have been met annually. If 100%			
	available to show a the facility analyzed the		compliance is not achieved, an			
	response of the actual emergency event and no documentation could be found of a conducted		action plan will be put into place			
	second exercise of choice.		by ED/Designee.			
	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.					
, 0000						
( 0000						
Bldg. 01						
	A Life Safety Code Recertification and State	K 0000	The creation and submission of			
	Licensure Survey was conducted by the Indiana		this plan of correction does not			
	Department of Health in accordance with 42 CFR		constitute an admission by this			
	483.90(a).		provider of any conclusion set forth			
			in the statement of deficiencies, or			
	Survey Date: 11/06/23		of any violation of regulation. This provider respectfully requests that			
	Facility Number: 000092		the 2567 Plan of Correction be			
	Provider Number: 155176		considered the letter of credible			
	AIM Number: 100266090		allegation and requests a desk			
		1	review in lieu of a post survey	1		

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STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  01			(X3) DATE SURVEY COMPLETED	
MIDITAN	or condition	155176	B. WING 11/06/202					
NAME OF P	ROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD ARNELL AVE			
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CENT	ER		WAYNE, IN 46805			
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG		<u> </u>	DATE	
	_	Code survey, Glenbrook Skilled Nursing Center was			revisit on or after December 2 2023.	22,		
		iance with Requirements for			2023.			
	-	dicare/Medicaid, 42 CFR						
	_	Life Safety from Fire and the						
		National Fire Protection						
		a) 101, Life Safety Code (LSC),						
	· ·	g 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							
	-	orridors. Battery operated						
		ve been installed in the						
		e 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							
K 0353	NFPA 101							
SS=C Bldg. 01	Sprinkler System	- Maintenance and Testing						
-	Based on record rev	view, observation, and	K 0	353	-What corrective action(s) will	be	12/22/2023	
	interview, the facili	ty failed to maintain 1 of 1			accomplished for those reside	ents		
	automatic sprinkler	systems in accordance with			found to have been affected b	y the		
	NFPA 25. LSC 9.7	7.5 requires all sprinkler systems			deficient practice:			
	_	tested, and maintained in						
		FPA 25, Standard for the			No residents were negatively			
	-	, and Maintenance of			affected by the alleged deficie	ent		
		Protection Systems. NFPA 25,			practice.			
		on 4.1.4.1 states the property						
		d representative shall correct			-How other residents having t			
	_	es or impairments that are			potential to be affected by the			
	found during the in	spection, test and maintenance	1		same deficient practice will be	9	1	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>01</u>			COMPLETED		
		155176	B. W	B. WING			2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CEN	ΓER		VAYNE, IN 46805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG			DATE
		ndard. Corrections and repairs			identified and what corrective		
		by qualified maintenance			action(s) will be taken:		
		ified contractor. NFPA 25,					
		ds shall be made for all			All residents have the potentia		
	_	nd maintenance of the system			be affected. Facility contacted		
		all be made available to the			to service sprinkler heads in a		
		risdiction upon request. This			space. Loaded sprinkler head		
	_	ould affect all residents, staff,			other areas of facility have bee	en	
	and visitors in the fa	acting.			repaired.		
	Findings include:				-What measures will be put in	to I	
	i manigo metade.				place or what systemic change		
	Based on records re	eview of Fire Sprinkler System			will be made to ensure that the		
		ntation dated 08/09/23 with the			deficient practice does not rec		
	_	the Director of Property				u	
	_	he Maintenance Director on			The Maintenance Director will		
	_	.m., the deficiencies section			check sprinkler heads in attic		
		kler heads throughout the			space at least monthly.		
		ed or covered with paint. There			,		
	was documentation	stating parts are on order and			-How the corrective action(s) v	vill	
	work on the sprinkl	er heads should begin in the			be monitored to ensure the		
		Based on observation between			deficient practice will not recur		
		p.m., about a quarter of			i.e. What quality assurance		
		he building had signs of paint,			program will be put into place:		
		ut a quarter of sprinkler heads					
		sulation. Based on interview			Sprinkler head checks will be		
		d review, the Director of			conducted by Maintenance		
		ent stated the facility is aware			Director/Designee weekly x 4		
		vaiting on parts to complete			weeks and then monthly there		
	the repairs.				to ensure sprinkler heads are	not	
	7E1 (* 1'	. 1 M 4 E TV			loaded. IDT will review any	.	
		viewed with the Facilities			negative findings at the month		
	_	tor of Property Management,			QA meeting and an action plan	1	
	conference.	de Director at the exit			will be put into place with any negative findings.		
	conference.				negauve iiiuliigs.		
	3.1-19(b)						
K 0712	NFPA 101						
SS=C	Fire Drills						

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 11/06/2023		
	PROVIDER OR SUPPLIER	FION & SKILLED NURSING CEN	TER	3811 PA	ADDRESS, CITY, STATE, ZIP COD ARNELL AVE VAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ίΤΕ	(X5) COMPLETION DATE
Bldg. 01	failed to conduct que times under varying for 4 of 4 quarters. affect all residents, affect all residents. Based on records re Manager, the Direct and the Maintenance a.m., all second shift drills took place at affect and the conducte on interview at the topicetor of Property second shift fire drill unexpected times.  The finding was rev Manager, the Direct	view and interview, the facility arterly fire drills at unexpected conditions on second shift. This deficient practice could staff and visitors in the facility.  view with the Facilities for of Property Management, the Director on 11/06/23 at 10:00 ft (2:00 p.m. to 10:00 p.m.) fire foretween 3:00 p.m. and 4:15 p.m. not allow fire drills on second did at unexpected times. Based time of records review, the symmetry Management agreed all lists were not conducted at the property Management, the Director at the exit.	KO	0712	-What corrective action(s) will accomplished for those reside found to have been affected by 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 be affected. Fire drills will be conducted at various, unexpetimes by the Maintenance Diremonthly.  -What measures will be put in place or what systemic chang will be made to ensure that the deficient practice does not recomply the deficient practice does not requirements are met monthly based upon previous months.  -How the corrective action(s) the monitored to ensure the deficient practice will not recurred. What quality assurance program will be put into place.  ED/Designee will review months.	ents by the ent  he al to cted ector  nto es ected re will r,	12/22/2023

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CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				OM	B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155176		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			X3) DATE SURVEY COMPLETED 11/06/2023		
NAME OF PROVIDER OR SUPPLIER GLENBROOK REHABILITATION & SKILLED NURSING CEN		STREET ADDRESS, CITY, STATE, ZIP COD 3811 PARNELL AVE NTER FORT WAYNE, IN 46805					
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ë	(X5) COMPLETION DATE
K 0920	NFPA 101				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 meetir and any negative findings will negate an action plan.	ng	
SS=E Bldg. 01	Extens Based on observatifailed to ensure 2 of were not used as an wiring. NFPA-70/2 specifically permit cables shall not be fixed wiring. Artic chains, because the strip) is now acting wiring of a structuraffect up to 15 resicompartment.  Findings include:  Based on observatified Director of Promaintenance Director of Promaintenance Director on and supplied programment.	con and interview, the facility of 2 power cord daisy chains and as a substitute for fixed 2011, 400.8 state unless ted in 400.7 flexible cords and used for (1) as a substitute for le 400.8 (1) prohibits daisy as a substitute for the fixed re. This deficient practice could dents in one smoke  Ton with the Facilities Manager, perty Management, and the ctor on 11/06/23 at 11:38 a.m., in the a power strip was plugged power by another power strip. The time of observation, the agreed a power strip was daisy power strip.	K 0	920	-What corrective action(s) will be accomplished for those resider found to have been affected by 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 hospit grade surge protectors, each plugged into their own outlets.	nts  the  the  ce  d.  call  stal	11/25/2023
	The finding was re	viewed with the Facilities			-What measures will be put int		

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conference.

Manager, the Director of Property Management,

and the Maintenance Director at the exit

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will be made to ensure that the

deficient practice does not recur:

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION  A. BUILDING 01  B. WING  STREET ADDRESS, CITY, STATE, ZIP COD		(X3) DATE SURVEY COMPLETED 11/06/2023		
		TION & SKILLED NURSING CENT		ARNELL AVE WAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)  Maintenance Director will cond		(X5) COMPLETION DATE
	3.1-19(b)			Maintenance Director will conducted audits of rooms in facility to ensure the alleged deficient practice does not recur.  -How the corrective action(s) who be monitored to ensure the deficient practice will not recur i.e. What quality assurance program will be put into place:  Maintenance Director/Designed will audit rooms in facility week 4 weeks, monthly x 6 months, quarterly until 100% compliance maintained for 12 months. Responding monthly. If any negatifindings, an action plan will be implemented.	vill  ee kly x and ce is sults A	

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