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

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155176		JILDING	ONSTRUCTION	(X3) DATE COMPL 12/12/	ETED
	ROVIDER OR SUPPLIER	TION & SKILLED NURSING CEN	TER	3811 P	ADDRESS, CITY, STATE, ZIP COD ARNELL AVE WAYNE, IN 46805	•	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
E 0039 SS=C Bldg	conducted by the Inaccordance with 42 Survey Date: 12/12 Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this Emergency I Glenbrook Rehability Center was found in Emergency Prepared Medicare and Medicand Suppliers, 42 Chapacity of 82 and hof this survey. Quality Review com 403.748(d)(2), 446 441.184(d)(2), 482 483.73(d)(2), 484. 485.68(d)(2), 485. 486.360(d)(2), 491 EP Testing Requires \$416.54(d)(2), \$418 \$483.475(d)(2), \$428 \$483.475(d)(2), \$438 \$485.625(d)(2), \$448 \$485.625(d)(2), \$448	722 70092 755176 766090 Preparedness survey, tation and Skilled Nursing a substantial compliance with dness Requirements for eaid Participating Providers FR 483.73. The facility has a had a census of 57 at the time 757 758 758 759 769 779 760 779 770 770 770 77	E 0	000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set in the statement of deficiencie of any violation of regulation. Provider respectfully requests the 2567 Plan of Correction be considered the letter of credib allegation and requests a desireview in lieu of a post survey revisit on or after February 18 2023.	ot s : forth s, or This that e le k	
	OPO, "Organization CMHCs at §485.92	6.54, CORFs at §485.68, ons" under §485.727, 20, RHCs/FQHCs at D Facilities at §494.62]:					

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

(X6) DATE

TITLE

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 8MPV21 Facility ID: 000092 If continuation sheet Page 1 of 37

PRINTED: 02/22/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155176	î ´	UILDING	NSTRUCTION	(X3) DATE COMPI 12/12	
	PROVIDER OR SUPPLIEI	TION & SKILLED NURSING CE	NTER	3811 PA	DDRESS, CITY, STATE, ZIP COL ARNELL AVE VAYNE, IN 46805)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
	exercises to test t annually. The [fac following: (i) Participate in a	facility] must conduct he emergency plan cility] must do all of the full-scale exercise that is					
	(A) When a common accessible, confunctional exercis (B) If the [faction actural or man-material content in the common state of	l every 2 years; or munity-based exercise is onduct a facility-based e every 2 years; or ility] experiences an actual ade emergency that requires mergency plan, the [facility]					
	community-based functional exercis actual event. (ii) Conduct an ad	ngaging in its next required I or individual, facility-based e following the onset of the Iditional exercise at least posite the year the full-scale					
	or functional exer- (i) of this section i include, but is not (A) A second full-	cise under paragraph (d)(2) s conducted, that may limited to the following: scale exercise that is I or individual, facility-based					
	. ,	er drill; or ercise or workshop that is and includes a group					
	set of problem sta messages, or pre to challenge an el	pared questions designed					
	maintain documer exercises, and en the [facility's] eme	ntation of all drills, tabletop nergency events, and revise ergency plan, as needed.					
	*[For Hospices at	418.113(d):]					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

8MPV21 Facility ID: 000092

If continuation sheet Page 2 of 37

PRINTED: 02/22/2023 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMP	LETED
		155176	B. W				2/2022
		100170	Б. W		<u> </u>	12/12	., _ U_L
NAME OF	DDOLUDED OD GUDDU IEI			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	K		3811 P	ARNELL AVE		
GLENBF	ROOK REHABILITA	TION & SKILLED NURSING CEN	NTER	FORT V	WAYNE, IN 46805		
710 TD	T				T		775
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE	IATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(2) Testing for ho	spices that provide care in					
	the patient's home	e. The hospice must					
	conduct exercises	s to test the emergency					
		ıally. The hospice must do					
	the following:	•					
	1	a full-scale exercise that is					
		l every 2 years; or					
	-	nunity based exercise is not					
	1 ` '						
		uct an individual facility					
		exercise every 2 years; or					
		experiences a natural or					
		gency that requires activation					
		plan, the hospital is					
		aging in its next required full					
	scale community-	based exercise or individual					
	facility-based fund	ctional exercise following the					
	onset of the emer	gency event.					
	(ii) Conduct an a	dditional exercise every 2					
	years, opposite th	ne year the full-scale or					
	functional exercis	e under paragraph (d)(2)(i)					
		conducted, that may					
		limited to the following:					
		-scale exercise that is					
	, ,	or a facility based					
	functional exercis	-					
	(B) A mock disas	•					
	` '	ercise or workshop that is					
	1 ' '	and includes a group					
		- · · · · · · · · · · · · · · · · · · ·					
	discussion using						
		emergency scenario, and a					
	-	atements, directed					
		pared questions designed					
	to challenge an e	mergency plan.					
		spices that provide inpatient					
		hospice must conduct					
	exercises to test t	the emergency plan twice					
	per year. The hos	spice must do the following:					
	1 ' '	an annual full-scale exercise					

FORM CMS-2567(02-99) Previous Versions Obsolete

that is community-based; or

Event ID:

 $8MPV21 \qquad {\tt Facility \, ID:} \quad 000092$

If continuation sheet

Page 3 of 37

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155176		UILDING	NSTRUCTION	(X3) DATE COMPL 12/12/	ETED
	PROVIDER OR SUPPLIER	TION & SKILLED NURSING CEN	TER	3811 PA	DDRESS, 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 APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	(A) When a commaccessible, conduct facility-based functions a community-based functional exercise emergency event. (ii) Conduct an act that may include, lefollowing: (A) A second full-community-based functional exercises (B) A mock disast (C) A tabletop exercise facilitator that inclusing a narrated, cemergency scena statements, direct questions designed emergency plan. (iii) Analyze the homaintain documer exercises, and emergency scena statements, direct questions designed emergency plan. (iii) Analyze the homaintain documer exercises, and emergency scena statements, direct questions designed emergency plan. (iii) Analyze the homaintain documer exercises, and emergency plan. (iii) Analyze the homaintain documer exercises, and emergency plan. (iii) Participate in a that is community-fall must do the (i) Participate in a that is community-fall when a community-f	unity-based exercise is not ct an annual individual tional exercise; or experiences a natural or ency that requires activation plan, the hospice is ging in its next required ity based or facility-based e following the onset of the ditional annual exercise but is not limited to the scale exercise that is or a facility based e; or ter drill; or ercise or workshop led by a udes a group discussion clinically-relevant rio, and a set of problem ed messages, or prepared ed to challenge an cospice's response to and entation of all drills, tabletop hergency events and revise regency plan, as needed. 41.184(d), Hospitals at at §485.625(d):] PRTF, Hospital, CAH] must to test the emergency r. The [PRTF, Hospital, following: n annual full-scale exercise					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

8MPV21 Facility ID: 000092

If continuation sheet Page 4 of 37

	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155176		JILDING	NSTRUCTION	(X3) DATE COMPL 12/12/	ETED
	ROVIDER OR SUPPLIER	TION & SKILLED NURSING CEN	TER	3811 PA	DDRESS, CITY, STATE, ZIP COD ARNELL AVE VAYNE, IN 46805		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LL COURSE THE VINCE DIFFERENCE TO SERVE THE VINCE DEFENDANCE TO SERVE THE VINCE DIFFERENCE TO SERVE THE VINCE DIFFERENCE TO SERVE THE VINCE DIFFERENCE TO SERVE THE VI		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG	facility-based functions (B) If the [PRTF, For Pace at §46 (2) Testing. The Pace at substitution of the pace at least annuorganization must (B) If the PACE expensed functions (C) A to the pace at least annuorganization must (A) When a community-based functions (B) A more (C) A to the pace at least annuorganization must (C) A to the pace at least annuorganization must (C) A to the pace at least annuorganization must (C) A to the pace at least annuorganization must (C) A to the pace at least annuorganization must (E) Participate in a that is community (A) When a community-based functions (B) If the PACE expensed to the pace at least annuorganization must (B) If the PACE expensed to the pace at least annuorganization accessible, conductions (B) If the PACE expensed to the pace at least annuorganization accessible, conductions (B) If the PACE expensed to the pace at least annuorganization accessible, conductions (B) If the PACE expensed to the pace at least annuorganization accessible, conductions (B) If the PACE expensed to the pace accessible	dospital, CAH] experiences or man-made emergency ation of the emergency is exempt from engaging in all-scale community based ty-based functional exercise it of the emergency event. In [additional] annual at may include, but is not wing: scale exercise that is or individual, a stional exercise; or ck disaster drill; or exercise or workshop that or and includes a group a narrated, emergency scenario, and a tements, directed bared questions designed mergency plan. The [facility's] response to amentation of all drills, is, and emergency plan, as		TAG	DATKIENC!!		DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

8MPV21 Facility ID: 000092

If continuation sheet Page 5 of 37

PRINTED: 02/22/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155176		UILDING	NSTRUCTION	COMP	E SURVEY LETED 2/2022
	PROVIDER OR SUPPLIEI	R TION & SKILLED NURSING CEN	NTER	3811 PA	DDRESS, CITY, STATE, ZIP COD ARNELL AVE VAYNE, IN 46805	•	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE	(X5) COMPLETION
TAG	activation of the exist exempt from error full-scale community-based functional exercises of this section is of this section in this section is of this section is	an additional exercise every the year the full-scale or e under paragraph (d)(2)(i) conducted that may include, to the following: -scale exercise that is d or individual, a facility exercise; or eter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan. PACE's response to and intation of all drills, tabletop mergency events and revise gency plan, as needed. es at §483.73(d):] ity] must conduct exercises ency plan at least twice per mannounced staff drills using rocedures. The [LTC facility, the following: an annual full-scale exercise e-based; or nunity-based exercise is not act an annual individual,		TAG	DEFICIENCY		DATE
		n of the emergency plan, the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

8MPV21 Facility ID: 000092

If continuation sheet Page 6 of 37

PRINTED: 02/22/2023

	T OF HEALTH AND HU R MEDICARE & MEDIC						ORM APPROVED MB NO. 0938-039
	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155176	ì	UILDING	ONSTRUCTION	COMP	E SURVEY LETED 2/2022
NAME OF	PROVIDER OR SUPPLIEI	3	•		ADDRESS, CITY, STATE, ZIP COD ARNELL AVE		
GLENBI	ROOK REHABILITA	TION & SKILLED NURSING CEN	NTER	FORT V	WAYNE, IN 46805		
(X4) ID	SUMMARY	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 APPROPR	IATE	COMPLETION
TAG	 	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	required a full-scalindividual, facility-following the onset (ii) Conduct an act that may include, following: (A) A second full-community-based based functional of the based of the	ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan. LTC facility] facility's maintain documentation of exercises, and emergency e the [LTC facility] facility's as needed. \$483.475(d)]: CF/IID must conduct the emergency plan at least the ICF/IID must do the In annual full-scale exercise rbased; or munity-based exercise is not act an annual individual, ctional exercise; or.					
	(B) If the ICF/IID	experiences an actual ade emergency that requires					
		mergency plan, the ICF/IID					

FORM CMS-2567(02-99) Previous Versions Obsolete

is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the

Event ID:

8MPV21

Facility ID: 000092

If continuation sheet

Page 7 of 37

PRINTED: 02/22/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155176			JILDING	NSTRUCTION	(X3) DATE COMPL 12/12	LETED
	PROVIDER OR SUPPLIEI	TION & SKILLED NURSIN	IG CENTE	R	3811 PA	ODDRESS, CITY, STATE, ZIP COD ARNELL AVE VAYNE, IN 46805		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FU	LL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA)TE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMAT	ON		TAG	DEFICIENCY)		DATE
	onset of the emer	gency event.						
	(ii) Conduct an ad	lditional annual exercise						
	that may include,	but is not limited to the						
	following:							
		scale exercise that is						
	community-based							
		ctional exercise; or						
	(B) A mock disast							
		ercise or workshop that is						
		and includes a group						
	discussion, using							
	· ·	emergency scenario, and	a					
		atements, directed						
		pared questions designed						
	to challenge an e							
		CF/IID's response to and						
		ntation of all drills, tabletop						
		nergency events, and revis	е					
	the ICF/IID's eme	rgency plan, as needed.						
	*[For HHAs at §48	84.102]						
	(d)(2) Testing. Th	e HHA must conduct						
	exercises to test t	he emergency plan at						
	least annually. Th	e HHA must do the						
	following:							
	(i) Participate in a	full-scale exercise that is						
	community-based	l; or						
	(A) When a c	community-based exercise						
		conduct an annual						
		based functional exercise						
	every 2 years; or.							
	' '	A experiences an actual						
		ade emergency that require						
		mergency plan, the HHA is	8					
		aging in its next required						
		nity-based or individual,						
		ctional exercise following th	ie					
	onset of the emer	-						
	· ·	Iditional exercise every 2						
	years, opposite th	ne year the full-scale	or					1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

8MPV21 Facility ID: 000092

If continuation sheet Page 8 of 37

PRINTED: 02/22/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155176	A. E	MULTIPLE CO BUILDING VING	NSTRUCTION	COMI	E SURVEY PLETED 2/2022
	PROVIDER OR SUPPLIER	TION & SKILLED NURSING CE	NTER	3811 PA	.DDRESS, CITY, STATE, ZIP COI ARNELL AVE VAYNE, IN 46805)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
	of this section is of include, but is not include, but is not (A) A second community-based facility-based function (B) A mock d (C) A tableton is led by a facilitated discussion, using clinically-relevant set of problem statemessages, or preto challenge an erection (iii) Analyze the Hemaintain documerexercises, and enthe HHA's emergential (b) Conduct a paper or workshop at lease exercise is led by group discussion, relevant emergen problem statementemer prepared question emergency plantactual natural or requires activation OPO is exempt for required testing exercises, and emergency (ii) Analyze the Ofmaintain documerexercises, and emergency exercises, and emergency exercises.	limited to the following: full-scale exercise that is or an individual, ctional exercise; or isaster drill; or o exercise or workshop that for and includes a group a narrated, emergency scenario, and a itements, directed pared questions designed mergency plan. HA's response to and intation of all drills, tabletop mergency events, and revise ency plan, as needed. 86.360] e OPO must conduct the emergency plan. The following: er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically cy scenario, and a set of ints, directed messages, or ins designed to challenge an lif the OPO experiences an inan-made emergency plan, the om engaging in its next exercise following the onset					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

8MPV21 Facility ID: 000092

If continuation sheet Page 9 of 37

DEPARTMENT OF HEALTH AND HUN	MAN SERVICES		FORM APPR
CENTERS FOR MEDICARE & MEDICA	AID SERVICES		OMB NO. 093
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED
	155176	B. WING	12/12/2022

NAME OF PROVIDER OR SUPPLIER

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

(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
TAG	needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCl's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCl's emergency plan, as needed. Based on record review and interview, the facility failed to provide complete documentation for the second exercises of choice to test the Emergency Preparedness Plan (EPP). 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	E 0039	Glenbrook Rehabilitation & Skilled Nursing Center will complete documentation related to actual disaster that occurred in April 2022. In addition, the tabletop exercise will be repeated by February 18, 2023 with complete documentation and review of policies. Glenbrook Rehabilitation will maintain continued efforts to ensure drills/exercises are completed annually including unannounced drills. To ensure this deficiency does not occur again, the Safety Committee will review the training and testing requirements within the emergency preparedness plan at least annually and anytime amendments are made. Executive Director, Maintenance Director, and Safety Committee will be responsible.	02/18/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

8MPV21 Facility ID: 000092

If continuation sheet Page 10 of 37

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155176		Ĺ	JILDING	NSTRUCTION	(X3) DATE : COMPL 12/12/	ETED	
	PROVIDER OR SUPPLIER	TION & SKILLED NURSING CENT	ER	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)	TE	(X5) COMPLETION DATE
	facilitator that inclu a narrated, clinically and a set of problem messages, or prepar challenge an emerge (iii) Analyze the LT maintain documenta exercises, and emergator that it is accordance with 42 deficient practice construction of the findings include: Based on records re on 12/12/22 at 10:12 required EPP exercitor 04/14/22 were incomprovide stating a taban actual emergency forms did not indicate were used, and anal Based on interview the Administrator against include the scenused, nor analyzing. This finding was reconstructed to the Administrator against include the scenused, nor analyzing.	C facility's response to and ation of all drills, tabletop gency events, and revise the gency plan, as needed in CFR 483.73(d)(2). This build affect all occupants. View with the Administrator 2 a.m. and at 2:00 p.m., both ses conducted on 04/11/22 and mplete. A sign in sheet was pletop drill was conducted and y event happened, but the tet the scenario, what policies yzing the facility's response. at the time of records review, greed the documentation did ario, what EEP policies were the facility's response					
E 0041 SS=C Bldg	§482.15(e) Condit (e) Emergency and The hospital must standby power sys	LTC Emergency Power ion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

8MPV21 Facility ID: 000092

If continuation sheet

Page 11 of 37

PRINTED: 02/22/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155176		A. BUILDING <u></u>				C3) DATE SURVEY COMPLETED 12/12/2022	
	PROVIDER OR SUPPLIER	TION & SKILLED NURSING CENT	TER	3811 PA	DDRESS, CITY, STATE, ZIP COD ARNELL AVE VAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION et forth in paragraphs (b)(1)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	(i) and (ii) of this s §483.73(e), §485.1 (e) Emergency an The [LTC facility a implement emerge systems based on forth in paragraph §482.15(e)(1), §48 Emergency generator must be the location requir Care Facilities Co- Interim Amendment 12-4, TIA 12-5, an Code (NFPA 101 Amendments TIA and TIA 12-4), and structure is built of structure or buildir 482.15(e)(2), §483 Emergency generator The [hospital, CAI- implement the em inspection, testing requirements foun Facilities Code, NI Code. 482.15(e)(3), §483 Emergency generator and LTC facilities] source to power en have a plan for ho	d standby power systems. Ind the CAH] must ency and standby power the emergency plan set (a) of this section. 33.73(e)(1), §485.625(e)(1) ator location. The c located in accordance with ements found in the Health de (NFPA 99 and Tentative ints TIA 12-2, TIA 12-3, TIA d TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new when an existing ing is renovated. 3.73(e)(2), §485.625(e)(2) ator inspection and testing. H and LTC facility] must ergency power system , and [maintenance] d in the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) ator fuel. [Hospitals, CAHs that maintain an onsite fuel mergency generators must w it will keep emergency erational during the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

8MPV21 Facility ID: 000092

If continuation sheet Page 12 of 37

	T OF DEFICIENCIES OF CORRECTION	ES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155176		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMPL	(X3) DATE SURVEY COMPLETED 12/12/2022	
	PROVIDER OR SUPPLIER	TION & SKILLED NURSING CEN	TER	3811 PA	DDRESS, CITY, STATE, ZIP COD ARNELL AVE VAYNE, IN 46805			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING DIFFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	HOULD BE COMPLET COMPLET		
TAG	*[For hospitals at § §483.73(g), and O The standards ince this section are appreference by the E Federal Register i 552(a) and 1 CFR the material from the You may inspect a Information Resour Boulevard, Baltimy Archives and Reco (NARA). For information this material at NA go to: http://www.archive_of_federal_regulated from the Fannounce the character (1) National Fire Fannounce (1) National Fire Fannounc	roges. Protection Association, 1 K, D, www.nfpa.org, th Care Facilities Code, ed August 11, 2011. im amendment (TIA) 12-2 to August 11, 2011. FPA 99, issued August 9, FPA 99, issued March 7, PA 99, issued August 1, FPA 99, issued March 3, FPA 99, issued March 3, FPA 99, issued March 3,		TAG			DATE	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

8MPV21 Facility ID: 000092

If continuation sheet Page 13 of 37

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r /		ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155176	B. W	ING		12/12/	2022
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CENT	ER		ARNELL AVE VAYNE, IN 46805		
(X4) ID	T	STATEMENT OF DEFICIENCIE	 	ID			(X5)
					PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	DATE
PREFIX TAG	REGULATORY OR 11, 2011. (ix) TIA 12-2 to NF 30, 2012. (x) TIA 12-3 to NF 22, 2013. (xi) TIA 12-4 to NF 22, 2013. (xiii) NFPA 110, S Standby Power Sy including TIAs to or 2009. Based on records re failed to implement requirements found Code, NFPA 110, a accordance with 42 deficient practice co Findings include: Based on records re on 12/12/22 at 10:0 monthly load testing required by LSC an interview at the tim Administrator states some of the required	FPA 101, issued October FPA 101, issued October FPA 101, issued October tandard for Emergency and ystems, 2010 edition, chapter 7, issued August 6, eview and interview, the facility the emergency power system in the Health Care Facilities and Life Safety Code in CFR 483.73(e)(2). This build affect all occupants. Eview with the Administrator 2 a.m., the generator lacked g and weekly inspections d NFPA 110. Based on e of record review, the d the generator was missing d testing.	E 00		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	be ents at ee ener to es eeing ice.	O1/07/2023
					How the facility will monitor its		
	accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator on 12/12/22 at 10:02 a.m., the generator lacked monthly load testing and weekly inspections required by LSC and NFPA 110. Based on interview at the time of record review, the Administrator stated the generator was missing some of the required testing. The findings were reviewed with the Administrator and Maintenance Director at the				will be backup if Maintenance Director not available. How will the facility identify off residents having the potential be affected by the deficient practice: The facility recognize that all residents, staff, and visitors have the potential of b affected by the deficient practi What measures will be put in place or systemic changes ma to ensure that the deficient practice will not recur: Maintenance Director will main documentation in Life Safety Binder. Maintenance Director given 1:1 education by Execut	ner to es eeing ice. ade ntain was tive	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

8MPV21 Facility ID: 000092

If continuation sheet Page 14 of 37

PRINTED: 02/22/2023 FORM APPROVED

ENTERS FOR MEDICARE & MEDIC	OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED
	155176	R WING	12/12/2022

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP COD

3911 DARNELL ΔVE

(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
			corrective action to ensure that the deficient practice is being corrected and not recur: Maintenance Director will document monthly and weekly generator checks and bring any identified issues to the monthly QA meeting to ensure compliance and to determine if further action is deemed necessary.	
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: 12/12/22 Facility Number: 000092 Provider Number: 155176 AIM Number: 100266090 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	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 revisit on or after February 18, 2023.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $8MPV21 \qquad {\it Facility ID:} \quad 000092$

If continuation sheet

Page 15 of 37

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDIN 155176 B. WING		UILDING	onstruction 01	(X3) DATE COMPL 12/12/	ETED	
	PROVIDER OR SUPPLIEF	TION & SKILLED NURSING CEN	ITER	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 R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0211 SS=E Bldg. 01	resident rooms. The and had a census of All areas where the access are sprinkers services are sprinkers services are sprinkers. We also of Egress Means of Egress Means of Egress Aisles, passagewidischarges, exit loin accordance with of egress is continuall obstructions to emergency, unless through 18/19.2.1, 7.1 Based on observation failed to ensure 1 of doors and 1 of 2 coopen from the inside doors complying we 7.2.1.5.1 Door leav opened readily from building is occupied staff that use house freezer. Findings include: Based on observation building is occupied staff that use house freezer. Findings include:	- General - General ays, corridors, exit cations, and accesses are n Chapter 7, and the means auously maintained free of full use in case of s modified by 18/19.2.2 110.1 on and interview, the facility of 1 housekeeping storeroom oler/freezer doors were able to e if locked. LSC 19.2.2.1 states ith 7.2.1 shall be permitted. es shall be arranged to be n the egress side whenever the d. This deficient practice could keeping supplies and the	KC	211	K-0211 #1: 1.The identified pad lock on the rear housekeeping storeroom been removed 2.No other doors were identified a concern. 3.Housekeeping Staff have the potential to be affected. 4.The IDT team was educated the Executive Director that parallocks are not to be used on an doors. 5.The IDT team will check for locks during routine customer care rounds. Maintenance Direction will report findings to QA	has ed as e d by d ny pad ector	02/18/2023
		keeping storeroom door was ck from the outside and there			committee for appropriate folloup for at least 6 months. If 100		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

8MPV21 Facility ID: 000092

If continuation sheet Page 16 of 37

PRINTED: 02/22/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155176 B. WING 12/12/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3811 PARNELL AVE GLENBROOK REHABILITATION & SKILLED NURSING CENTER FORT WAYNE. IN 46805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE was no release from the inside to open the door if threshold is not met an action plan lock with the pad lock. There was a second exit will be developed. door, but it was locked with a padlock from the inside and would not unlock do to there was no K-0211 # 2: key. This condition could trap a person inside the storeroom if locked from the outside. Based on 1. The identified release handle interview at the time of observation, the inside the walk-in freezer was Administrator agreed the housekeeping storeroom repaired to function properly door was locked with a padlock and could not 2.No other doors were identified as open from the inside when locked. a concern. 3. Staff who use the walk-in #2. The walk-in freezer release handle on the freezer have the potential to be inside to open the door did not work. This affected. condition could trap a person inside the freezer 4. The Culinary Staff was educated when latched shut. Based on interview at the time by the Executive Director that if of observation, the Maintenance Director and the the emergency handle was not Administrator agreed the freezer release handle functioning properly at any time, to was not working and stated the release alert Executive Director/ mechanisms would need to be repaired. Maintenance Director immediately 5. Maintenance Director will check The findings were reviewed with the functioning of handle weekly. Administrator and Maintenance Director during Maintenance Director will report the exit conference. findings to QA committee for appropriate follow up for at least 6 3.1-19(b). months. If 100% threshold is not met an action plan will be developed. K 0222 **NFPA 101** SS=F **Egress Doors** Bldg. 01 **Egress Doors** Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following

FORM CMS-2567(02-99) Previous Versions Obsolete

LOCKING

special locking arrangements:

CLINICAL NEEDS OR SECURITY THREAT

Event ID:

8MPV21

Facility ID: 000092

If continuation sheet

Page 17 of 37

PRINTED: 02/22/2023 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155176		A. B	MULTIPLE CO BUILDING VING	nstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 12/12/2022	
	PROVIDER OR SUPPLIER	TION & SKILLED NURSING CEN	ITER	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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	Where special lociclinical security neused, only one locipermitted on each be made for the raby: remote control locks or keys carriother such reliable staff at all times. 18.2.2.2.5.1, 18.2. 19.2.2.2.6 SPECIAL NEEDS ARRANGEMENTS Where special locks afety needs of the Clinical or Secare being met. In a electrical locks that release upon loss building is protected automatic sprinkle space is protected detection system (at an attended locispace); and both the systems are arran upon activation. 18.2.2.2.5.2, 19.2. DELAYED-EGRES ARRANGEMENTS Approved, listed designed in systems installed in the contents in building an approved, supersonance in special systems in stalled in the contents in building an approved, supersonance in special security.	king arrangements for the eds of the patient are king device shall be door and provisions shall apid removal of occupants of locks; keying of all ed by staff at all times; or means available to the 2.2.6, 19.2.2.2.5.1, LOCKING Sking arrangements for the e patient are used, all of eurity Locking requirements addition, the locks must be at fail safely so as to of power to the device; the ed by a supervised or system and the locked at on within the locked he sprinkler and detection ged to unlock the doors 2.2.5.2, TIA 12-4 SS LOCKING Selayed-egress locking in accordance with permitted on door g low and ordinary hazard gs protected throughout by ervised automatic fire or an approved, supervised or system. 2.4					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

8MPV21 Facility ID: 000092

If continuation sheet

Page 18 of 37

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	ETED
		155176	B. W	ING		12/12/	2022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			ARNELL AVE		
GLENBR	ROOK REHABILITA	TION & SKILLED NURSING CEN	TER		WAYNE, IN 46805		
(V4) ID	CLIMMADAY	STATEMENT OF DEFICIENCIE	1	ID	<u> </u>		(V5)
(X4) ID PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	``	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
IAG	LOCKING ARRAI			IAG			DATE
		d Egress Door assemblies					
		dance with 7.2.1.6.2 shall					
	be permitted.	Jan 100 With 7 .2. 1.0.2 Shall					
	18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS						
	LOCKING ARRAI						
		it access door locking in					
	1	7.2.1.6.3 shall be permitted					
		es in buildings protected					
	throughout by an	approved, supervised					
	automatic fire det	ection system and an					
	approved, superv	ised automatic sprinkler					
	system.						
	18.2.2.2.4, 19.2.2						
		on and interview, the facility	K 0	222	1.The identified access control	ol	01/07/2023
		means of egress through 3 of			pad codes have been posted visibly on the access control pad		
	· ·	accessible for residents					
		iagnosis requiring specialized			for all staff, residents, and visi	tors	
		Doors within a required means			to see in order to exit.		
	1 -	be equipped with a latch or					
	_	ne use of a tool or key from the			2.The Executive Director has		
	_	otherwise permitted by LSC			ensured that all codes posted	are	
		ocking arrangements shall be			the correct codes to exit all		
	_	lance with 19.2.2.2.5.2. This			identified doors via the access		
	deficient practice co	ould all residents.			control pads. All residents, sta		
	Findings include:				and visitors have the potential be affected.	i iO	
	i maniga metude.				DE AIIEULEU.		
	Based on observation	on with the Administrator on			3.The Maintenance Director w	<i>l</i> as	
		11:00 a.m. and 1:10 p.m., the			educated by the Executive		
		en the magicianly locked exit			Director on posting and updat	ina	
		1, 231, and the lounge had the			the codes on the access conti	-	
		. When the posted codes were			pads if the codes are changed		
		ad, the doors did not unlock.					
		when the correct code was			4.The Maintenance Director w	/ill	
	_	nterview at the time of			oversee monthly checks of ac		
	observation, the Ad	lministrator stated the posted			control pads for proper posting		
		ct to help prevent elopements.			codes and functionality. The	-	
		•			Maintenance Director will repo	ort	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED		
		155176	B. Wl	ING		12/12/	/2022
	ROVIDER OR SUPPLIER	TION & SKILLED NURSING CEN	TER	STREET ADDRESS, CITY, STATE, ZIP COD 3811 PARNELL AVE FORT WAYNE, IN 46805			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	viewed with the Administrator irector during the exit			findings to QA committee for appropriate follow up annually 100% threshold is not met an action plan will be developed.	. If	
K 0226	NFPA 101						
SS=E	Horizontal Exits						
Bldg. 01	Horizontal Exits						
2.03							
	Based on observation failed to ensure 1 of were arranged to au LSC section 7.2.4.3 assemblies in horizon or automatic-closing Standard for Fire Do Protectives, section doors shall swing ea equipped with a clost oclose and latch ead efficient could affect compartments when Findings include: Based on observation with the Administration of the barrier by the 3-hour rated fire does exit and as a smoke the door leaves failed Based on interview.	Based on observation and interview, the facility failed to ensure 1 of 6 horizontal exit fire door sets were arranged to automatically close and latch. LSC section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic-closing. In addition, NFPA 80, the Standard for Fire Doors and Other Opening Protectives, section 6.1.4.2.1 states self-closing doors shall swing easily and freely and shall be equipped with a closing device to cause the door to close and latch each time it is opened. This deficient could affect 30 residents in 2 smoke compartments when occupied.		226	1. The identified smoke barrier door by the north nurse's station was repaired to latch properly. 2. All smoke barrier doors have been checked to ensure proper latching. Staff and at least 30 residents have the potential to be affected. 3. The Maintenance Director was educated on K226 by the Executive Director. All other doors were examined by the Maintenance Director to ensure compliance with K226. The Maintenance Director was educated on ensuring all smoke barrier doors latch properly. Rounds were completed by the ED and the Maintenance Director to ensure that all smoke barrier doors latch properly.		02/18/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

8MPV21

Facility ID: 000092

If continuation sheet

Page 20 of 37

PRINTED: 02/22/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155176			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING 01 COMPLETED B. WING 12/12/202			LETED	
	PROVIDER OR SUPPLIER	FION & SKILLED NURSING CEN	TER	3811 P	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)		(X5) COMPLETION DATE
		viewed with the Administrator irector during the exit			make rounds daily x 4 weeks then weekly x 4 weeks then monthly for at least 6 months ensure that all doors close and latch into the door frame. The Executive Director will monitor rounds are completed and that smoke barrier doors latch daily weeks then weekly x 4 weeks then monthly for at least 6 months. The results of the monitoring will be forwarded to committee.	to d r that t all y x 4	
K 0291 SS=F Bldg. 01	duration is provide accordance with 7 18.2.9.1, 19.2.9.1 Based on records refailed to ensure 21 owere tested monthly functional testing should be with a minimum of weeks between tests and (5) Written records shall be kept by the authority having practice could affect Findings include: Based on records reform on 12/12/22 at 9:39 monthly 30 second emergency lighting conducted for Nove	ng g of at least 1-1/2-hour d automatically in	K 0:	291	How the corrective action will accomplished for those reside found to be affected by the deficient practice: No Residen was directly affected by the deficient practice. Regional Maintenance Director/Designe will be backup if Maintenance Director not available. How will the facility identify oth residents having the potential be affected by the deficient practice: The facility recognize that all residents, staff, and visitors have the potential of b affected by the deficient practice. What measures will be put in	nts t ee ner to es eing	01/07/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

8MPV21

Facility ID: 000092

If continuation sheet

Page 21 of 37

PRINTED: 02/22/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155176	B. WI	NG	-	12/12/	/2022
						,	
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CENT	ER	FORT V	WAYNE, 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	TF	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Administrator state	d the testing was missed due			place or systemic changes ma	ıde	
	to lack of maintenar	nce personnel.			to ensure that the deficient		
					practice will not recur:		
	This finding was re	viewed with the Administrator			Maintenance Director will mair	ntain	
and Maintenance Director during the exit				documentation in Life Safety			
	conference.				Binder. Maintenance Director	was	
					given 1:1 education by Execut	ive	
	3.1-19(b)				Director.		
					How the facility will monitor its		
					corrective action to ensure that	t the	
					deficient practice is being		
					corrected and not recur:		
					Maintenance Director will		
					document monthly emergency	'	
					lighting checks and bring any		
					identified issues to the monthly	•	
					QA meeting to ensure complia		
					and to determine if further acti	on is	
					deemed necessary.		
K 0300	NFPA 101						
SS=F	Protection - Other						
Bldg. 01	Protection - Other						
Diag. 01		RKS section any LSC					
	Section 18.3 and	-					
		are not addressed by the					
		out are deficient. This					
	-	with the applicable Life					
		FPA standard citation, d on Form CMS-2567.					
			17.0	200	Liqui the corrective estion will i	ha	01/07/2022
	failed to ensure doc	view, interview, the facility	K 0	300	How the corrective action will l		01/07/2023
		enance of 40 of 40 battery			accomplished for those reside	1115	
	_	rms in resident rooms was			found to be affected by the	+	
	_	01 in 4.6.12.3 states existing life			deficient practice: No Residen	ι	
	-	_			was directly affected by the		
		ous to the public, if not			deficient practice. Regional		
		le, shall be maintained. NFPA			Maintenance Director/Designe	е	
	/2, 29.10 Maintena	nce and Tests. Fire-warning	I		will be backup if Maintenance		

FORM CMS-2567(02-99) Previous Versions Obsolete

equipment shall be maintained and tested in

Event ID:

8MPV21 Facility ID: 000092

Director not available.

If continuation sheet Page 22 of 37

PRINTED: 02/22/2023 FORM APPROVED OMB 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 12/12/2022		
	PROVIDER OR SUPPLIEF	TION & SKILLED NURSING CENT	STREET ADDRESS, CITY, STATE, ZIP COD 3811 PARNELL AVE FORT WAYNE, IN 46805				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY 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)	ΓE	(X5) COMPLETION DATE
	instructions and per 14. NFPA 72, 14.2. maintenance progra requirements of this equipment manufac	e manufacturer's published the requirements of Chapter 1.1.1 Inspection, testing, and ams shall satisfy the s Code and conform to the sturer's published instructions. ice could affect all building			How will the facility identify oth residents having the potential be affected by the deficient practice: The facility recognize that all residents, staff, and visitors have the potential of be affected by the deficient practi. What measures will be put in place or systemic changes ma	to s eing ce.	
	on 12/12/22 at 9:49 battery-operated sm tests were conducte on an interview at t	eview with the Administrator a.m., the documentation of the noke alarm testing showed no d for November 2022. Based the time of record review, the d the testing was missed due nce personnel.			to ensure that the deficient practice will not recur: Maintenance Director will main documentation in Life Safety Binder. Maintenance Director given 1:1 education by Execut Director.	was	
		viewed with the Administrator irrector during the exit			How the facility will monitor its corrective action to ensure that deficient practice is being corrected and not recur: Maintenance Director will document monthly battery-operated smoke alarm testing checks and bring any identified issues to the monthly QA meeting to ensure complia and to determine if further actideemed necessary.	t the	
K 0341 SS=F Bldg. 01	and components a accordance with N Code, and NFPA						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

8MPV21 Facility ID: 000092

If continuation sheet Page 23 of 37

PRINTED: 02/22/2023

	Γ OF HEALTH AND HUI R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155176	A. B B. W	UILDING 'ING	01	COMPLETED 12/12/2022	
	PROVIDER OR SUPPLIER	TION & SKILLED NURSING CEN	ITER	3811 P	ADDRESS, CITY, STATE, ZIP COD ARNELL AVE WAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	occupied, detectical alarm control unit. detection is also in appliance circuit properties alarm system transmission path integrity. 18.3.4.1, 19.3.4.1 Based on observation failed to ensure 1 or protected. NFPA 7 Signaling Code Secturning off activated appliance(s) shall be with 10.10.3 through the means shall be a locked cabinet or protection against undeficient practice construction. Findings include: Based on observation 12/12/22 at 12:00 protected at the north cabinet but the door when checked lock.	s are monitored for 9.6, 9.6. 1.8 on and interview, the facility f 1 fire alarm control panel was 2, National Fire Alarm and stion 10.10.1 states a means for d alarm notification e permitted only if it complies th 10.10.7. Section 10.10.3 states key-operated or located within arranged to provide equivalent mauthorized use. This build affect all occupants. on with the Administrator on .m., the fire control panel nurses station was in a r to the cabinet was unlocked . This condition does not m system against unauthorized	K)341	Corrective actions were as fo Maintenance Director was educated on K341 NFPA 70, National Electric Code and N 72, National Fire Alarm Code Executive Director. Executive Director removed key and prostored key to protect against unauthorized use in accordar with NFPA 70 and 72. Nursin staff educated per Maintenan Director as to location of store key.	FPA , by operly oce g ce	01/07/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

conference.

3.1-19(b)

observations, the Administrator agreed the cabinet door to the fire control panel was not properly secured and did lock the door.

This finding was reviewed with the Administrator and Maintenance Director during the exit

Event ID:

8MPV21

Facility ID: 000092

If continuation sheet

Page 24 of 37

PRINTED: 02/22/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES							OMB 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 12/12/2022		
	PROVIDER OR SUPPLIER	TION & SKILLED NURSING CEN	ITER	3811 P	ADDRESS, CITY, STATE, ZIP COD ARNELL AVE WAYNE, IN 46805)		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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)	TE	(X5) COMPLETION DATE	
K 0353 SS=F Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testin Water-based Fire Records of system inspection and tes secure location ar a) Date sprinkler b) Who provided c) Water system Provide in REMAR coverage for any automatic sprinkle 9.7.5, 9.7.7, 9.7.8 Based on record rev interview, the facili sprinkler system in which requires all a be inspected and m NFPA 25. Table 5.1 frequency of inspect 4.1.4.1 states the pr representative shall or impairments that inspection, test and standard. 5.2.1.1.1 s signs of leakage; sh foreign materials, p shall be installed in	supply source RKS information on non-required or partial er system.	K 0	0353	K353 #1: 1.The dry pendants for the code and freezer have been ordered the outside vendor, however, puill not arrive for more than 90 days after the survey exit date temporary waiver has been requested. As soon as parts arrive, outside vendor will instance. No other pendants are in near replacement 3.All occupants of the facility has the potential to be affected. 4.The Maintenance Director we ducated that if any sprinkler	d by parts) . A all. ed of	04/30/2023	

FORM CMS-2567(02-99) Previous Versions Obsolete

Findings include:

Event ID:

8MPV21

Facility ID: 000092

heads have been identified that

they are in need of replacement, they should be replaced by vendor

If continuation sheet

Page 25 of 37

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 12/12/2022 155176 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3811 PARNELL AVE GLENBROOK REHABILITATION & SKILLED NURSING CENTER FORT WAYNE. IN 46805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Based on observation and records review with the as soon as possible. Administrator on 12/12/20 between 10:00 a.m. and 5.The Maintenance Director will 1:00 p.m., the following deficiencies were found: review all sprinkler checks completed by outside vendor with #1. The inspection form for the sprinkler system Executive Director. Maintenance dated 08/17/22 stated, "Total of two dry pendants Director will report findings to QA in the cooler and freezer are due to be replaced." committee for appropriate follow No documentation was provided to show the dry up for at least 6 months. If 100% pendants were replaced. Also during observation, threshold is not met an action plan the dry pendants were not replaced and showed will be developed. signs of corrosion. Based on an interview at the time of record review and observation, the K353 # 2: Administrator stated the dry pendants have not been replaced How the corrective action will be accomplished for those residents #2. The inspection documentation for the gauges found to be affected by the and valves on the sprinkler system showed no deficient practice: No Resident tests were conducted for November 2022. Based was directly affected by the on an interview at the time of record review, the deficient practice. Regional Administrator stated the testing was missed due Maintenance Director/Designee to lack of maintenance personnel. will be backup if Maintenance Director not available. #3 during observation, In the break room the deflector on the side wall sprinkler head by the How will the facility identify other door was bent down and not in the correct residents having the potential to orientation. Based on an interview at the time of be affected by the deficient observation, the Administrator agreed the practice: The facility recognizes deflector was bent down and not in the correct that all residents, staff, and orientation for complete coverage of the room. visitors have the potential of being affected by the deficient practice. The findings were reviewed with the Administrator and Maintenance Director during What measures will be put in the exit conference. place or systemic changes made to ensure that the deficient 3.1-19(b)practice will not recur: Maintenance Director will maintain documentation in Life Safety Binder, Maintenance Director was given 1:1 education by Executive Director.

PRINTED: 02/22/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155176		(X2) MULTIPLE C A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 12/12/2022			
	PROVIDER OR SUPPLIER	TION & SKILLED NURSING CENT	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 R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE	
				How the facility will monitor its corrective action to ensure that deficient practice is being corrected and not recur: Maintenance Director will document monthly sprinkler system checks and bring any identified issues to the monthl QA meeting to ensure complicand to determine if further actideemed necessary. K353 # 3: 1. The identified sprinkler heads the break room was corrected be in the correct orientation 2. No other sprinkler heads are found to be in incorrect orientation 3. All occupants of the facility if the potential to be affected. 4. The Maintenance Director with check all sprinkler heads according to TELS system. Maintenance Director will report findings to QA committee for appropriate follow up for at least months. If 100% threshold is met an action plan will be developed.	y ance ion is d in to eation. have will ast 6		
K 0511 SS=E	NFPA 101 Utilities - Gas and	Electric					

FORM CMS-2567(02-99) Previous Versions Obsolete

Utilities - Gas and Electric

Bldg. 01

Event ID:

8MPV21

Facility ID: 000092

If continuation sheet

Page 27 of 37

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 12/12/2022 155176 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3811 PARNELL AVE GLENBROOK REHABILITATION & SKILLED NURSING CENTER FORT WAYNE. IN 46805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility K 0511 K511 #1: 01/07/2023 failed to ensure 1 of 2 electrical boxes in in the riser room was securely fastened in place and 1 of 1.The identified electrical box was 10 junction boxes in the attic was provided with a remounted cover. LSC 9.1.2 requires electrical wiring and 2.No other electrical boxes are in equipment to comply with NFPA 70. Article need of remounting 314.28(3) (c) states junction boxes shall be 3.15 residents have the potential provided with covers compatible with the box and to be affected. suitable for the conditions of use. Article 406.5 4. The Maintenance Director will states receptacles shall be mounted in boxes or monitor all electrical boxes weekly assemblies designed for the purpose, and such for 4 weeks, monthly for 6 months boxes or assemblies shall be securely fastened in until 100% compliance is place unless otherwise permitted elsewhere in this achieved. Maintenance Director Code. This deficient practice could affect 15 will report findings to QA residents in two smoke compartments. committee for appropriate follow up for at least 6 months. If 100% Findings include: threshold is not met an action plan will be developed. Based on observation with the Administrator and the Maintenance Director on 12/12/22 at 11:48 a.m. K511 #2: and at 1:11 p.m., the following was observed: 1.The identified exposed electrical #1 In the riser room there was an electrical box junction box was covered hanging from the ceiling exposing wires. Based on 2.No other electrical junction interview at the time of observation, the boxes are exposed Administrator agreed the box was not fasten 3. 15 residents have the potential securely and would need to be remounted. to be affected. 4. The Maintenance Director will #2 In the center attic there was an electrical monitor all electrical junction junction box without a cover and had exposed boxes weekly for 4 weeks, electrical wiring. Based on interview at the time of monthly for 6 months until 100%

FORM CMS-2567(02-99) Previous Versions Obsolete

the observations, the Maintenance Director

acknowledged the electrical junction box was not

Event ID:

8MPV21

Facility ID: 000092

compliance is achieved.

Maintenance Director will report

If continuation sheet

Page 28 of 37

DEPARTMENT OF HEALTH AND HU	MAN SERVICES		ŀ
CENTERS FOR MEDICARE & MEDIC	AID SERVICES		(
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DA

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155176	B. WI	NG		12/12/2022	
NAME OF P	ROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP COD		
		TION & SKILLED NURSING CENT	ER	3811 PARNELL AVE FORT WAYNE, IN 46805			
(X4) ID	SHMMADV	STATEMENT OF DEFICIENCIE	1	ID	· 		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG		CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	DATE
provided with a cover and had exposed wires.			findings to QA committee for				
	•	•			appropriate follow up for at lea	ıst 6	
	The findings were r	eviewed with the			months. If 100% threshold is not		
	Administrator and N	Maintenance Director during			met an action plan will be		
	the exit conference.				developed.		
	3.1-19(b)						
K 0712	NFPA 101						
SS=F	Fire Drills						
Bldg. 01	Fire Drills						
ŭ	Fire drills include t	he transmission of a fire					
	alarm signal and s	simulation of emergency fire					
	-	ills are held at expected	-				
	and unexpected ti	· · · · · · · · · · · · · · · · · · ·					
	conditions, at leas	t quarterly on each shift.					
	The staff is familia	r with procedures and is					
	aware that drills ar	re part of established					
		ills are conducted between					
	9:00 PM and 6:00						
		ay be used instead of					
	audible alarms.						
	19.7.1.4 through 1		17.00	-10			01/05/2022
		riew and interview, the facility	K 0'	712	How the corrective action will be		01/07/2023
		e drills on each shift for 1 of 4			accomplished for those reside	nts	
		1.6 states drills shall be			found to be affected by the		
		on each shift to familiarize nurses, interns, maintenance			deficient practice: No Resident	ι	
		inistrative staff) with the			was directly affected by the deficient practice. Regional		
		ncy action required under			Maintenance Director/Designe	.	
		his deficient practice affects			will be backup if Maintenance		
	all staff and residen	-			Director not available.		
	an stair and residen				Bircolor flot available.		
	Findings include:				How will the facility identify oth	ner	
					residents having the potential		
	Based on records re	view with the Administrator			be affected by the deficient		
	on 12/12/22 at 9:32	a.m., no documentation was			practice: The facility recognize	:S	
	available to show a	first shift fire drill for the third			that all residents, staff, and		
	_	conducted. Based on			visitors have the potential of be	eing	
	interview at the time	e of record review, the			affected by the deficient practi-	ce.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

8MPV21 Facility ID: 000092

If continuation sheet

Page 29 of 37

PRINTED: 02/22/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE				SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETE			ETED	
		155176	B. WI	NG		12/12/2022	
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P.	ROVIDER OR SUPPLIER			3811 PA	ARNELL AVE		
GLENBR	OOK REHABILITAT	TION & SKILLED NURSING CENT	ER FORT WAYNE, IN 46805		VAYNE, IN 46805		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION I the aforementioned drill was		TAG	DEFICIENCIT		DATE
		o there was no Maintenance			What measures will be put in		
	Director during that				place or systemic changes ma	de	
	British during that			to ensure that the deficient			
	This finding was rev	viewed with the Administrator			practice will not recur:		
	and Maintenance Di	irector during the exit			Maintenance Director will mair	ıtain	
	conference.				documentation in Life Safety		
	2.1.10(1)				Binder. Maintenance Director		
	3.1-19(b)				given 1:1 education by Execut	ive	
	3.1-51(c)				Director.		
					How the facility will monitor its		
					corrective action to ensure tha		
					deficient practice is being		
					corrected and not recur:		
					Maintenance Director will		
					document monthly fire drills ar		
					ensure that all shifts have at le	ast	
					one drill completed quarterly.		
					Maintenance Director will bring any identified issues to the	3	
					monthly QA meeting to ensure	!	
					compliance and to determine i		
					further action is deemed		
					necessary.		
K 0741	NEDA 101						
SS=E	NFPA 101 Smoking Regulation	one					
Bldg. 01	Smoking Regulation						
Diag. 01		ns shall be adopted and					
		ess than the following					
	provisions:	Ü					
	(1) Smoking shall	be prohibited in any room,					
	-	nent where flammable					
	•	le gases, or oxygen is					
		d in any other hazardous					
		area shall be posted with					
	-	SMOKING or shall be ernational symbol for no					
	smoking.	omatorial symbol 101 110					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

8MPV21 Facility ID: 000092

If continuation sheet

Page 30 of 37

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155176	B. WI	NG _		12/12	/2022
		1	<u> </u>	STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ARNELL AVE		
GLENBE	OOK REHARII ITA	TION & SKILLED NURSING CENT	FR		NAYNE, IN 46805		
OLLINDIN		TION & SKILLED NOROING CENT			, , , , , , , , , , , , , , , , , , ,		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1 ' '	occupancies where					
	smoking is prohib	-					
	1 .	d at all major entrances,					
		vith language that prohibits					
	smoking shall not	· · · · · · · · · · · · · · · · · · ·					
	1 ' '	atients classified as not					
	responsible shall						
	1 ' '	ent of 18.7.4(3) shall not					
	1	atient is under direct					
	supervision.						
	1 ' '	ncombustible material and					
	_	be provided in all areas					
	where smoking is						
	l ` '	ers with self-closing cover					
		n ashtrays can be emptied					
	1	vailable to all areas where					
	smoking is permit	ted.					
	18.7.4, 19.7.4	1	17.0	- 4.1			01/07/0000
		on and interview; the facility	K 0'	/41	1.The identified inappropriate		01/07/2023
		f 2 smoking areas were			disposal of cigarette butts hav	е	
		osing cigarette butts in a metal container with self-closing			been properly disposed of. A	_	
		deficient practice could affect			noncombustible container was		
	staff and 10 residen	•			placed in the staff smoking are	₽d.	
	starr and 10 residen	us in the courtyald.			2 All smoking residents and a	toff	
	Findings include:				All smoking residents and s have been re educated on pro		
	i mamga metade.				cigarette disposal. All staff have	•	
	Based on observativ	on with the Administrator on			been in-serviced on the smoki		
		.m. and 12:23 p.m., in the			policy.	ıı ıy	
		smoking area there were over			policy.		
		isposed on the ground in and			3.The Maintenance Director w	/as	
		g area. Also, in the staff			educated by the Executive		
		were 25 cigarette butts			Director that the facility staff a	nd	
	1	ound. Based on interview at			resident smoking areas need		
		tions, the Administrator agree			free of improperly disposed	.5 50	
		butts on the ground in the			cigarette butts. Maintenance		
	aforementioned loc				director also educated on nee	d to	
					make sure compliance is		
	This finding was re	viewed with the Administrator			maintained.		
		rirector during the exit					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

8MPV21 Facility ID: 000092

If continuation sheet Page 31 of 37

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155176		, ,	JILDING	ONSTRUCTION (X3	(X3) DATE SURVEY COMPLETED 12/12/2022		
	PROVIDER OR SUPPLIER	TION & SKILLED NURSING CEI	STREET ADDRESS, CITY, STATE, ZIP COD 3811 PARNELL AVE ENTER FORT WAYNE, IN 46805				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 0761	conference. 3.1-19(b)				4. The Maintenance Director will oversee the proper disposal of cigarette butts in the resident and staff smoking areas and that the areas will be free of cigarette butts. The Maintenance Director will report findings to QA committee for appropriate follow up monthly for 6 months. If 100% threshold is not met an action pla will be developed.		
SS=E Bldg. 01	failed to maintain 2 accordance with NF device, equipment, arrangement, level of feature is required f provision of this Co system, condition, a protection, or other maintained unless the maintained unless the maintenance. NFP assemblies shall be than annually, and a inspection shall be shy the AHJ. This do residents in the maintenance in the maintained unless the system of the	of protection, or any other for compliance with the ode, such device, equipment, arrangement, level of feature shall thereafter be the Code exempts such A 80 5.2.1 requires fire door inspected and tested not less a written record of the signed and kept for inspection efficient practice could affect 25	K 0	761	1.The identified rolling fire window have been repaired to drop 2.No other rolling fire doors in the facility 3.Up to 25 residents in the main dining room have the potential to be affected. 4.The Maintenance Director was educated that if any equipment have been identified that they are in need of repair, they should be repaired by vendor as soon as possible. 5.The Maintenance Director will review all rolling fire door checks completed by outside vendor with Executive Director. Maintenance Director will report findings to QA committee for appropriate follow up for at least 6 months. If 100% threshold is not met an action pla will be developed.		

FORM CMS-2567(02-99) Previous Versions Obsolete

12:30 p.m., there were two rolling fire windows

Event ID:

8MPV21

Facility ID: 000092

If continuation sheet

Page 32 of 37

PRINTED: 02/22/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155176		ľ	UILDING	nstruction 01	(X3) DATE COMPL 12/12/	ETED		
	PROVIDER OR SUPPLIER	TION & SKILLED NURSING CEN	NTER	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 LISC 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	
K 0918 SS=C Bldg. 01	between the kitcher window dropped whafter testing the man interview at the tim review, the Administ Director agreed both when tested and have the finding was revand Maintenance Director agreed both when tested and have the finding was revand Maintenance Director agreed both when tested and have the finding was revand Maintenance Director and Maintenance Director and Systems Electrical Systems Electrical Systems System Maintenan The generator or source and associon of supplying service 10-second criterion monthly test, a proannually confirm the safety and critical and testing of the switches are performed in the switches are performed in the switches are performed in 20-40 day	and dining room. Neither then hitting the test button and mual release. Based on the of observation and records strator and the Maintenance the fire windows did not work the not been repaired. Wiewed with the Administrator during the exit the second of		TAG		ATE	DATE	
	Scheduled test un a complete simula automatic or manu loads, and are cor personnel. Mainte	der load conditions include ted cold start and ual transfer of all EES nducted by competent nance and testing of stored						
	accordance with N	rces (Type 3 EES) are in IFPA 111. Main and feeder e inspected annually, and a						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

8MPV21 Facility ID: 000092

If continuation sheet Page 33 of 37

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPLETED	
		155176	B. W	ING _		12/12/2022	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	₹			ARNELL AVE		
GI FNRR	OOK REHABII ITA	TION & SKILLED NURSING CENT	FR		WAYNE, IN 46805		
	·	TION & ONIELED NOTONING CENT		I OIKI V	1		
(X4) ID	SUMMARY	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	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		dically exercising the					
	-	tablished according to					
		uirements. Written records					
		nd testing are maintained					
	I -	ble. EES electrical panels					
		arked, readily identifiable,					
	1	n normal power circuits.					
		ssibility of damage of the					
	consideration for r	source is a design					
		(NFPA 99), NFPA 110,					
	NFPA 111, 700.10						
		view and interview, the facility	K 0	018	How the corrective action will	ha	01/07/2023
		complete written record of	KU	910	accomplished for those reside		01/07/2023
		load testing for 1 of 12 months			found to be affected by the	1113	
		ion for 12 of 52 weeks. Chapter			deficient practice: No Residen	ıt	
		12 NFPA 99 requires monthly			was directly affected by the	•	
		ator serving the emergency			deficient practice. Regional		
		be in accordance with NFPA			Maintenance Director/Designe	: e	
	· ·	or Emergency and Standby			will be backup if Maintenance		
		hapter 8. NFPA 110 8.4.2			Director not available.		
		erator sets in service to be					
		nce monthly, for a minimum of			How will the facility identify oth	ner	
	30 minutes. Section	8.4.1 requires an Emergency			residents having the potential		
	Power Supply Syste	em (EPSS) including all			be affected by the deficient		
	appurtenant compor	nents, shall be inspected			practice: The facility recognize	es:	
	_	ed monthly. Chapter 6.4.4.2 of			that all residents, staff, and		
	NFPA 99 requires a	a written record of inspection,			visitors have the potential of b	eing	
	1 ~	ising period, and repairs for the			affected by the deficient practi	ce.	
		ılarly maintained and available					
	for inspection by the	· ·			What measures will be put in		
	_ ·	eficient practice could affect all			place or systemic changes ma	ade	
	occupants.				to ensure that the deficient		
					practice will not recur:		
	Findings include:				Maintenance Director will main	ntain	
					documentation in Life Safety		
		eview with the Administrator			Binder. Maintenance Director		
		7 a.m., no documentation was			given 1:1 education by Execut	iive	
		onth of November 2022 to show			Director.		
	the generator set in	service was exercised at least					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

8MPV21 Facility ID: 000092

If continuation sheet Page 34 of 37

PRINTED: 02/22/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155176	ľ í	UILDING	onstruction 01	(X3) DATE SURVEY COMPLETED 12/12/2022
	PROVIDER OR SUPPLIER	TION & SKILLED NURSING CEN	ITER	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 R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE
	the generator weekly weekly inspection weeks. Based on an review, the Admini weekly tests were no Maintenance Direct The findings were roughly administrator and to the weekly tests were roughly and the findings were roughly as the findings were rou	eviewed with the he Maintenance Director			How the facility will monitor its corrective action to ensure the deficient practice is being corrected and not recur: Maintenance Director will document monthly and weekl generator checks and bring any identified issues to the monthly QA meeting to ensur compliance and to determine	at the y
	during the exit conf 3.1-19(b)	erence.			further action is deemed necessary.	
K 0923 SS=E Bldg. 01	Storag Gas Equipment - Storage Greater than or ec Storage locations and ventilated in a and 5.1.3.3.3. >300 but <3,000 c Storage locations enclosure or withi space of non- or li construction, with that can be secure stored with flamm from combustibles sprinklered) or en noncombustible c minimum 1/2 hr. fi Less than or equa In a single smoke cylinders available patient care areas of less than or equa	Cylinder and Container Cylinder and Container qual to 3,000 cubic feet are designed, constructed, accordance with 5.1.3.3.2 cubic feet are outdoors in an an enclosed interior mited- combustible door (or gates outdoors) ed. Oxidizing gases are not ables, and are separated as by 20 feet (5 feet if closed in a cabinet of construction having a are protection rating. all to 300 cubic feet compartment, individual as for immediate use in a with an aggregate volume and to 300 cubic feet are not ared in an enclosure.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

8MPV21 Facility ID: 000092

If continuation sheet Page 35 of 37

CENTERS FOR MEDICARE & MEDICAID SERVICES 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 12/12/2022

NAME OF PROVIDER OR SUPPLIER GLENBROOK REHABILITATION & SKILLED NURSING CENT			STREET ADDRESS, CITY, STATE, ZIP COD 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	
	Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 12 of 12 full and empty oxygen cylinders were separated and marked to avoid confusion. NFPA 99, Section11.6.5.2 states, if empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Section 11.6.5.3 states, empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner. This deficient practice could affect up to 30 residents in one smoke compartment. Findings include: Based on observations with the Administrator on 12/12/22 at 12:35 p.m., the oxygen storage room contained full and empty oxygen cylinders, but the cylinders were mixed together and not marked as full or empty. Based on interview at the time of observation, the Administrator stated the cylinders were not marked as full and empty.	K 09	923	How the corrective action will be accomplished for those residents found to be affected by the deficient practice: No Resident was directly affected by the deficient practice. How will the facility identify other residents having the potential to be affected by the deficient practice: The facility recognizes that up to 30 residents have the potential of being affected by the deficient practice. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: Maintenance Director will separate oxygen cylinders, filled and empty and label clearly with signs.	01/07/2023	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

8MPV21 Facility ID: 000092

If continuation sheet

Page 36 of 37

PRINTED: 02/22/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155176	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/12/2022		
NAME OF PROVIDER OR SUPPLIER GLENBROOK REHABILITATION & SKILLED NURSING CENTER STREET ADDRESS, CITY, STATE, ZIP COD 3811 PARNELL AVE 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)	TE	(X5) COMPLETION DATE	
	_	eviewed with the Administrator Director at the exit conference.		Maintenance Director/Designe will educate staff on process or keeping oxygen cylinders separate in oxygen room. How the facility will monitor its corrective action to ensure that deficient practice is being corrected and not recur: Maintenance Director will monioxygen room and bring any identified issues to the monthly QA meeting to ensure compliance and to determine it further action is deemed necessary.	f t the itor		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 8MPV21 Facility ID: 000092 If continuation sheet Page 37 of 37