STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155176	A. BUILDING 00 B. WING	12/06/2013

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

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F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: December 2, 3, 4, 5, and 6, 2013. Facility number: 000092 Provider number: 155176 AIM number: 100266090 Survey team: Diane Nilson, RN, TC Carol Miller, RN Rick Blain, RN Tim Long, RN Census bed type: SNF/NF: 67 Total: 67 Census payor type: Medicare: 4 Medicaid: 55 Other: 8 Total: 67 These deficiencies reflect State findings cited in accordance with 410	F000000	Glenbrook Rehabilitation and Skilled Nursing Center is requesting a desk review of the submitted plan of correction. We have attached documents supporting the identified CQI tools, trainings, and audits to be utilized in correcting the cited items. If you have further questions please contact Gregg Fuller Executive Director. We thank you for your consideration in this matter	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	IAC 16.2. Quality review completed on December 9, 2013 by Randy Fry RN.			

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F000156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,			

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	and how to receive refunds for previous payments covered by such benefits. Based on record review and interview, the facility failed to inform residents and/or responsible parties within 48 hours of Medicare Non-Coverage. This affected 2 of 3 residents reviewed for Liability Notice and Benefit Appeals, Residents # 90 and #30. Findings include: The Notice of Medicare Non-Coverage letter for Resident #90 was reviewed at 1:00 p.m., on 12/5/13. The letter indicated the last day of Medicare coverage was 8/17/13, but the responsible party was not notified of non-coverage until 9/17/13. The Notice of Medicare Non-Coverage letter for Resident #30 was reviewed at 1:00 p.m., on 12/5/13, and indicated the last day of Medicare coverage was 9/5/13, but the responsible party was not notified until 9/17/13. The Business Office Manager was interviewed, at 1:30 p.m., on 12/5/13. She indicated she began employment at the facility the end of April, 2013,	F000156	1. Resident #90 and 30 were notified of rights regarding Medicare non-covered2. A review of all residents discharged within the last 90 days was conducted and those affected will be notified of their rights in regards to Medicare non-coverage. 3. The Business office Manager was educated by the Executive Director as to the requirements of notification of Medicare Non-coverage. The SS director or designee will monitor daily in the morning meeting that the NOMNOC letters are issued timely.4. Executive Director or designee will monitor, using an audit tool (see attached) for compliance weekly for 2 weeks, then Monthly for 2 months, then quarterly for 6 months and forward results to monthly CQI committee for review. If any findings are out of compliance, then additional monitoring and an additional action plan will continue as determined by the committee. Compliance threshold is 90%. Non-compliance may result in disciplinary action up to and including termination.	12/27/2013

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	but didn't know it was her responsibility to send liability notices for Medicare non-coverage until 9/17/13, when she was informed by the corporate nurse. She indicated she began sending the late notice letters for Medicare non-coverage after 9/17/13. 3.1-4(f)(3)			

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F000248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on record review and interview the facility failed to provide one-to-one activities as scheduled for 1 of 1 residents reviewed for one-to-one activities. Findings include: On 12/2/13 at 11:17 A.M., an interview with Resident #73's husband indicated she did not attend activities anymore due to her Alzheimer's disease. Review of Resident #73's care plans on 12/4/13 at 10:30 A.M. indicated a care plan for activities which indicated the resident needed bed side stimulation for activities and would participate in a one-to-one program. An interview with the Acting Activities Director (AAD) on 12/4/13 at 11:00 A.M. indicated resident #73 was on a one-to-one activities therapy program on Mondays, Wednesdays and Fridays. The AAD provided	F000248	1. Resident #73 is now receiving 1:1 activities.2. An audit of all residents on 1:1 activity programs was conducted. All residents requiring 1:1 activities are receiving them per their care plan. 3. The activities department was educated by the Executive Director on 12/17 on proper completion of 1:1 program per the care plan. The activity Director will monitor weekly for 1:1 documentation as guided per the plan of care to ensure compliance.4. Executive Director or designee will monitor, using the Activity CQI tool for compliance weekly for 2 weeks, then Monthly for 2 months, then quarterly for 6 months and forward results to monthly CQI committee for review. If any findings are out of compliance, then additional monitoring and an additional action plan will continue as determined by the committee. Compliance threshold is 90%. Non-compliance may result in disciplinary action up to and including termination.	12/27/2013

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	documentation of Resident #73's participation in one-to-one activities on 9/30/13, 10/2/13, 10/7/13, 10/9/13, 11/20/13, 11/22/13, 11/27/13 and 11/29/13. The AAD indicated she did not know why Resident #73 did not receive scheduled Monday, Wednesday and Friday one-to-one activities between 10/9/13 and 11/20/13. An interview with RN #1 on 12/6/13 at 11:30 A.M. indicated no explanation for Resident #73 not being offered one-to-one activity therapy between 10/9/13 and 11/20/13 3.1-33(a)			

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F000280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on interview and record review, the facility failed to ensure 1 of 1 resident's ((#91) reviewed for quarterly care plan conferences, had a quarterly care plan conference. Findings include: An interview with resident #91's daughter on 12/3/13 at 2:10 P.M. indicated she was not invited for any care plan conferences since the initial admission conference in March 2013 until October of 2013. Record review indicated Resident #91	F000280	1. Resident #91 is current with all required care plans2. An audit was completed starting November 1st to current. Anyone identified as requiring a care plan has had a mailer sent to the POA and a hand delivered copy has been given to the resident.3. The Social Service Director has been educated on 12/17 by the Executive Director on proper care plan invitations. The Social Service consultant has also identified a new tracking system to ensue required care plans are not missed. The Social service Director implemented this tracking system and will be maintaining it going forward. 4. Executive Director or designee	12/27/2013

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	was admitted to the facility on 3/5/13 and a care plan conference was held on 3/13/13 at which the resident's sister attended. Record review indicated the next care plan conference was held on 10/21/13 which Resident #91's daughter attended. An interview with the Social Service Director (SSD) on 12/4/13 at 9:20 A.M. indicated the Resident #91's most recent care plan conference was held on 10/21/13 and the previous care plan conference had been held after admission on 3/13/13. Review of the facility policy provided by RN #1 on 12/4/13 at 1:59 P.M., titled Care Plan Review and Maintenance Process, original date 1/2010 and revised most recently on 8/20/11, indicated a "Care Plan review will be based on the MDS schedule for those residents who have had an Admission, Annual, Significant Change, Quarterly, Or Medicare MDS completed at a minimum of every 90 days"..." Resident, resident's families or others as designated by resident will be invited to care plan review." 3.1-35(c)(2)(C)		will monitor, using the Activity CQI tool and the Social Service CQI for compliance weekly for 2 weeks, then Monthly for 2 months, then quarterly for 6 months and forward results to monthly CQI committee for review. If any findings are out of compliance, then additional monitoring and an additional action plan will continue as determined by the committee. Compliance threshold is 90%. Non-compliance may result in disciplinary action up to and including termination.	

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to obtain a laboratory test as ordered by the physician for one resident (Resident #51) in a sample of five residents reviewed for laboratory tests. The facility also failed to ensure medications were administered as ordered by the physician for 1 of 6 residents reviewed for medication administration (Resident #19). Findings include: 1. The record for Resident #51 was reviewed on 12/4/2013 at 10:30 A.M. A nursing progress note, dated 11/05/2013 at 04:28 PM [Recorded as Late Entry on 11/10/2013 at 02:29 PM] indicated "resident returned from gastro (sic) with new orders. All orders noted. Family and pharm (sic) notified. A physician gastroenterology progress note, dated 11/5/2013 at 10:30 A.M., indicated "(check) H. pylori serology (a laboratory test to	F000282	1. The laboratory test for resident #51 was obtained. Resident #19 was monitored for any adverse side effects and the family and MD were notified. 2. An audit of orders from November 1st to present was completed for all laboratory orders was completed by the DNS and designees. All orders were identified and ensure timely completion. Skills validations were completed for all nurses by the DNS and designees to ensure proper medication procedures are followed to follow physician orders. 3. Nursing staff were educated on proper completion of laboratory orders and for proper medication pass techniques to ensure orders are followed. A system for checking all new orders as a resident returns from appointments was put into place to ensure orders are completed upon return. Medication competencies were completed on all nurses to ensure proper procedures are in place. DNS or designee will conduct rounds on all shifts to ensure medications are dispensed per MD orders. 4. Director of Nursing or designee will monitor, using the Laboratory CQI and the Med	12/27/2013

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	check for the presence of Helicobacter pylori, a bacteria that can cause stomach ulcers)". There was no documentation in Resident #51's record indicating the laboratory test had been obtained as ordered. The unit manager, LPN #4, was interviewed on 12/5/2013 at 11:15 A.M. During the interview, LPN #4 indicated the laboratory test had not been obtained as ordered. During the interview, LPN #4 indicated the nurse who had received the paperwork from the resident's gastroenterology appointment should have transcribed the order from the physician progress note onto a physician order form and then notified the laboratory. 2. On 12/4/13 at 8:42 A.M., LPN #5 was observed to administer Allopurinol (a medication for gout) 100 milligrams (mg), 2 tablets to Resident #19 orally. Review of the physician's order's for Resident #19 on 12/4/13 at 12:45 P.M. indicated an order for Allopurinol 100 mg, 1 tablet daily was received on 11/22/13.		Pass Competency Checklist tool for compliance weekly for 2 weeks, then Monthly for 2 months, then quarterly for 6 months and forward results to monthly CQI committee for review. If any findings are out of compliance, then additional monitoring and an additional action plan will continue as determined by the committee. Compliance threshold is 90%. Non-compliance may result in disciplinary action up to and including termination	

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	An interview with LPN #4 on 12/4/13 at 1:00 P.M. indicated Resident #19's Allopurinol order had been changed when she returned from the hospital on 11/22/13 from 200 mg to 100 mg daily. LPN #5 indicated the medication card the Allopurinol was administered from had directions to administer 100 mg, 2 tablets daily. LPN #5 indicated the current physician's order was Allopurinol 100 mg, 1 tablet daily. LPN #5 indicated Medication Administration Record for Resident #19 indicated she was to receive Allopurinol 100 mg daily. 3.1-35(g)(2)			

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F000314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on record review and interview, the facility failed to assess a pressure related wound each week for one resident (Resident #8) in a sample of 3 residents reviewed for pressure ulcers. Findings include: The record for Resident #8 was reviewed on 12/5/2013 at 12:30 P.M. A nursing note, dated 08/14/2013 at 11:37 P.M., indicated "A dry brown blister on the bottom of the right foot below fifth digit. New order for skin prep and heel protectors on while in bed." A nursing note, dated 8/15/2013 at 7:55 P.M., indicated "Blister is dry to the right foot below the fifth digit. Continue to skin prep the area."	F000314	1. Resident # 8 had a skin assessment completed and a wound assessment will be completed weekly.2. An audit was completed of all skin assessments for any open or healed wounds for the last two weeks. Any missing assessments identified were completed by the DNS and designee. 3. Nursing staff was educated by the Director of Nursing or Designee on proper assessments of a wound and required time frame for the assessment. DNS and designee will audit skin assessments weekly to ensure are completed weekly. 4. Director of Nursing or designee will monitor, using the Wound CQI tool for compliance weekly for 2 weeks, then Monthly for 2 months, then quarterly for 6 months and forward results to monthly CQI committee for review. If any findings are out of compliance, then additional monitoring and an additional	12/27/2013

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	A "Weekly Observation Report", dated 8/22/2013, indicated "Blister to RT (right) foot dry and skin prep done as ordered." A "Weekly Observation Report", dated 8/29/2013, did not include an assessment of the blister on the resident's right foot. A "Weekly Observation Report", dated 9/5/2013, did not include an assessment of the blister on the resident's right foot. A "Weekly Observation Report", dated 9/12/2013, did indicate "continues skin prep to outer foot fifth digit, small toe left foot," but did not include an assessment of the blistered area. A "Weekly Observation Report", dated 9/19/2013, did indicate "scabbed outer left foot (sic) skin prep tx (treatment) tolerated well...." There was no assessment of the blistered area. A "Weekly Observation Report", dated 9/26/2013, did include an assessment of the area, including "Skin prep to to outer left (sic) foot area scabbed no drainage fifth digit		action plan will continue as determined by the committee. Compliance threshold is 90%. Non-compliance may result in disciplinary action up to and including termination.	

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	155176	A. BUILDING 00 B. WING	12/06/2013

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	small toe...." A "Weekly Observation Report", dated 10/3/2013, did not include an assessment of the blister to the right foot. A "Weekly Observation Report", dated 10/10/2013, did not include an assessment of the blister to the right foot. There were no additional assessments of the blister to the resident's right foot documented in the "Weekly Observation Reports" or in the nursing progress notes until 10/15/2013 at 2:52 P.M., when the nurse documented in the nursing progress notes "Cap has come off the dry blister on the right lateral foot. New order was received for new treatment." A Pressure Wound Skin Evaluation Report dated 10/16/2013, indicated the facility wound nurse assessed the wound on the resident's right foot and indicated the area was an unstageable (scabbed) pressure ulcer measuring 1.5 cm (centimeters) by 1.5 cm. The area was described as dark brown/red and scabbed. The wound was then assessed			

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	weekly by the wound nurse after 10/16/2013. A facility policy entitled "Skin Management Program", dated 9/2013, and provided by the facility nurse consultant on 12/5/2013 at 1:00 P.M., indicated "All alterations in skin integrity will be documented in EMR (electronic medical record." The policy further indicated "The facility wound nurse will complete a further evaluation of the wounds identified." The policy further indicated "Wound rounds will be completed on a weekly basis to assess all wounds...." The facility nurse consultant was interviewed on 12/6/2013 at 10:45 A.M. During the interview, the nurse consultant indicated the blister on Resident #8's right foot should have been assessed weekly by the wound nurse after it was first noted. 3.1-40(a)(1)			

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F000514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interviews, the facility failed to document an assessment of a pressure area for 1 Resident #70, in a sample of 3 residents reviewed for pressure areas. Findings include: RN #2 was interviewed, at 3:08 p.m., on 12/2/13, and indicated Resident #70 was re-admitted to the facility on 12/1/13, and had a stage 1 red area on the coccyx, and the wound nurse was to evaluate the area on 12/2/13. The record for Resident #70 was reviewed at 10:00 a.m., on 12/3/13. An Admission/Readmission Comprehensive Admission	F000514	1. Resident #70 had documented wound assessment completed.2. All new/re-admissions from November 1st to present were audited for complete and documented wound assessments. Anyone found not in compliance was immediately completed. 3. Nursing staff was educated by 12/22 by the Director of Nursing or Designee on proper assessments of a wound and required time frame for the assessment. DNS or designee will monitor documentation on all new admissions to ensure all assessments are completed. 4. Director of Nursing or designee will monitor, using the Wound CQI tool for compliance weekly for 2 weeks, then Monthly for 2 months, then quarterly for 6 months and forward results to	12/27/2013

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	Assessment, dated 12/1/13 and completed by RN #3 at 5:39 p.m., indicated the resident had a pressure sore to the coccyx. The progress note on the Comprehensive Admission Assessment further indicated the resident was readmitted from the hospital on 12/1/13, and skin was pink, warm, and dry with Mepilex dressing to a wound on the coccyx. There was no further documentation regarding the description or staging of the pressure area on the coccyx. A physician's order, dated 12/1/13, indicated an order for Vasolex ointment twice a day to the coccyx. The wound nurse was interviewed, at 10:40 a.m. on 12/3/13 regarding documentation of wound assessments for Resident #70. She indicated the resident was re-admitted to the facility on Sunday, 12/1/13, and the nurse on duty was supposed to describe any wounds in nursing notes. She indicated she could not find an assessment of the resident's skin condition in the nursing notes. The wound nurse indicated she completed wound measurements including staging of wounds on Tuesdays and had worked on Tuesday 12/2/13, but had to leave		monthly CQI committee for review. If any findings are out of compliance, then additional monitoring and an additional action plan will continue as determined by the committee. Compliance threshold is 90%. Non-compliance may result in disciplinary action up to and including termination.	

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	unexpectedly, so didn't complete the skin assessment for Resident #70. She indicated she would assess the resident's skin today. Review of a pressure wound skin evaluation report at 1:25 p.m., on 12/3/13, and dated as completed on 12/3/13 at 1:05 p.m., by the wound nurse, indicated the following: Stage 2 pressure wound, present on admission 12/1/13, granulation(pink or red tissue with shiny, granular appearance), measuring 4.5 centimeters (cm) by 7.0 cm by 0.1 cm. The report indicated the area appeared red/dry/flaky, no open areas or drainage noted, appeared as abrasion, peri-wound intact and blanchable. The Current Treatment section of the pressure wound skin evaluation report indicated to discontinue Vasolex, and start treatment orders: wash red/flaky area on sacrum with warm water and mild antibacterial soap, rinse, and pat dry, apply 2 sprays skin prep to peri-wound, allow to air dry and cover with Allevyn thin dressing (4 inches by 4 inches) and change dressing every other day and as needed for soilage/dislodgement. RN #3, was interviewed, at 3:35 p.m.,			

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	on 12/4/13, regarding the pressure sore assessment. She indicated she worked on 12/1/13 when Resident #70 was re-admitted from the hospital. She indicated she completed the initial comprehensive admission assessment, which included a skin check. She indicated she removed the dressing, and observed the area on the resident's coccyx, and measured it. She indicated she documented a note on the initial admission assessment regarding the Mepilex dressing to the wound on the coccyx. She indicated she started documenting the "skin integrity" event form which was to be done if there was a skin issue, but did not complete it until today 12/4/13. She indicated she had measured the area on the coccyx and written it down on another paper, but didn't complete the documentation on the skin integrity form until 12/4/13 because she got busy and didn't have time to complete the form. The Corporate Nurse provided a copy of the Skin Integrity Events Pressure wound skin evaluation report, at 3:15 p.m., on 12/4/13. The report, dated as completed on 12/4/13 at 3:00 p.m., by RN #3, indicated new stage 2 non blanchable skin area, measuring 4.5 centimeters (cm) by 7.2 cm, by 0.1			

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	cm. The report indicated the area was red with open areas noted and no drainage. Review of the Skin management Program Policy, dated originally on 3/10/13, with the most recent update on 9/2013, which was provided by the Nurse Consultant, at 1:00 p.m., on 12/5/13, and reviewed at 1:15 p.m., on 12/5/13, indicated the following: A head to toe assessment would be completed by a licensed nurse upon admission/re-admission and documented on the Nursing Admission Assessment. Alterations in skin integrity would be reported to the physician and family member(s). All alterations in skin integrity would be documented on the Wound skin evaluation report-either pressure or non-pressure based on wound type. The policy further stated the licensed nurse would notify the wound nurse of any alterations in skin integrity, and a pressure risk assessment would be completed at admission or re-admission. 3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(f)(2)			

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