]	DEPARTMENT OF HEALTH AND HUMAN SERVICES									
•	CENTERS FOR MEDICARE & MEDICAID SERVICES									
	CTATEMENT OF DEFICIENCIES	V1) DDOVIDED/CLIDDLIED/CLIA	(V2) MIII TIDI E CONCEDIIO							

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155176		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 11/12/2024			ETED		
	ROVIDER OR SUPPLIER	FION & SKILLED NURSING CEN	TER	3811 P	ADDRESS, CITY, STATE, ZIP COD ARNELL AVE NAYNE, 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
E 0000	REGUERTORTOR	ESC IDENTIFY THIS INFORMATION		ing			DATE
Bldg			E 00	000	The facility respectfully reques paper compliance	sts	
	accordance with 42 Survey Date: 11/12 Facility Number: 00 Provider Number: 1	/24 00092					
	AIM Number: 1002 At this Emergency I Glenbrook Rehabilit Center was found in Emergency Prepared Medicare and Medicand Suppliers, 42 C capacity of 82 and hof this survey. Quality Review con	Preparedness survey, tation and Skilled Nursing a substantial compliance with dness Requirements for caid Participating Providers FR 483.73. The facility has a nad a census of 59 at the time					
E 0041 SS=C Bldg	Hospital CAH and Based on records re failed to implement requirements found Code, NFPA 110, at accordance with 42 deficient practice co-Findings include: Based on records re and Maintenance Dia.m., the generator I	(e), 485.542(e), 485.62 LTC Emergency Power view and interview, the facility the emergency power system in the Health Care Facilities and Life Safety Code in CFR 483.73(e)(2). This culd affect all occupants. view with the Administrator frector on 11/12/24 at 10:00 acked monthly load testing required by LSC and NFPA	E 00	041	The facility failed to implement emergency power system requirements found in Health (Facilities Code NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73 (e)(2). The deficient practice could affect a occupants. The generator lacked monthly testing and weekly checks required by LSC and NFPA 11 POC: The Maintenance Director ensisted.	Care d dee is all load	11/26/2024
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SI	GNATURI	E	TITLE		(X6) DATE

11/28/2024

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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Solomon

Jamie

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A		A. Bl	X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 11/12/2024				
	PROVIDER OR SUPPLIER	R TION & SKILLED NURSING CEN	STREET ADDRESS, CITY, STATE, ZIP COD 3811 PARNELL AVE FORT WAYNE, IN 46805				
GLENBR (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF 110. Based on an ir review, the Mainter generator was miss testing. The finding was rev Director of Property	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Interview at the time of record nance Director stated the ing some of the required viewed with the Administrator, y Management, and tor during the exit conference.	NTER	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) all weekly and monthly checks were current with no concerns noted. Weekly and monthly checks current as of 11/25/24. All residents could be affected. The Maintenance Director ensured all weekly and monthly checks were current. Weekly and monthly checks were current as of 11/25/24. To Ensure no other residents could be affected the Maintenance Director ensured all weekly and monthly tests are current as of 11/25/24. Will do checks weekly and monthly per schedule. The Maintenance Director will conduct and document inspection of generator weekly. The Maintenance Director will perform and document monthly load testing of generator. Weekly and monthly checks current. The Administrator will review documentation to ensure all tasks are completed timely weekly x 4 weeks then monthly x 6months or until deficiency is corrected using the attached audit tool. In the event the facility Maintenance Director is an open position or not		
K 0000 Bldg. 01	A Life Safety Code	Recertification and State	K 0	0000	available the Administrator will contact sister facilities for assistance. Date of compliance: 11/26/24 The facility respectfully requests		

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Licensure Survey was conducted by the Indiana

Event ID:

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paper compliance

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155176			JILDING	instruction <u>01</u>	COMPL	(3) DATE SURVEY COMPLETED 11/12/2024	
	ROVIDER OR SUPPLIER	TION & SKILLED NURSING CENT	STREET ADDRESS, CITY, STATE, ZIP COD 3811 PARNELL AVE NTER FORT WAYNE, IN 46805				
(X4) ID PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ΓE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION Ith in accordance with 42 CFR		TAG	DEFICIENCY		DATE
	Survey Date: 11/12	2/24					
	Facility Number: 00 Provider Number: 1 AIM Number: 1002	155176					
	Rehabilitation and S found not in compli Participation in Mes Subpart 483.90(a), 2012 edition of the Association (NFPA	Code survey, Glenbrook Skilled Nursing Center was iance with Requirements for dicare/Medicaid, 42 CFR Life Safety from Fire and the National Fire Protection) 101, Life Safety Code (LSC), g Health Care Occupancies and					
	determined to be of was fully sprinklere system with smoke areas open to the co smoke detectors have resident rooms. Th	ity with a basement was Type V (000) construction and ed. The facility has a fire alarm detection in the corridors and pridors. Battery operated we been installed in the e facility has a capacity of 82 Type 159 at the time of this survey.					
		residents have customary ed. All areas providing facility ered.					
	Quality Review cor	mpleted on 11/14/24					
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress	- General					
3	failed to ensure 2 of	on and interview, the facility f 2 records storeroom doors rom the inside if locked. LSC	K 0	211	The facility failed to ensure 2 or records storeroom doors were to open from the inside if locke	able	11/26/2024

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12/05/2024 PRINTED: DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED 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 11/12/2024 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 19.2.2.1 states doors complying with 7.2.1 shall be LSC 19.2.2.1 states doors permitted. 7.2.1.5.1 Door leaves shall be arranged complying with 7.2.1 shall be to be opened readily from the egress side permitted. 7.2.1.5.1 Door leaves whenever the building is occupied. This deficient shall be arranged to be opened practice could staff in the basement. readily from the egress side whenever the building is occupied. Findings include: This deficient practice could affect staff in basement. Based on observation with the Maintenance 2 records storeroom doors were Director, Director of Property Management, and locked with a padlock from the the Administrator on 11/12/22 at 12:33 p.m., the outside and there was no release two records storeroom doors were locked with a from the inside to open doors padlock from the outside and there was no release locked with the padlock. from the inside to open the doors if locked with POC: the padlock. This condition could trap a person The padlocks were immediately inside the storerooms if locked from the outside. removed. Based on an interview at the time of observation. All staff in basement could be the Maintenance Director agreed the storeroom affected. locks were removed doors were locked with a padlock, could not open immediately. from the inside when locked, and did remove the To ensure staff in basement are padlocks. not affected in future, locks were removed, and the Maintenance

The finding was reviewed with the Administrator, Director of Property Management, and Maintenance Director during the exit conference.

3.1-19(b)

K 0291 SS=F Bldg. 01

NFPA 101

Emergency Lighting

Based on records review, observation, and interview, the facility failed to ensure 10 of 10 battery backup lights were tested monthly.

K 0291

Director was in-serviced on

The Maintenance Director was in-serviced on appropriate locks for

doors. The Administrator will round monthly x 6 months or until the deficiency is corrected using the tool attached to ensure all doors are arranged to be opened readily

appropriate locks.

from the egress side.

Date of Compliance: 11/26/24

The facility failed to ensure 10 of

10 battery backup lights were

tested monthly. Section

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11/26/2024

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DEPARTMENT OF HEALTH AND HUMAN 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 B. WING 11/12/2024 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 Section 7.9.3.1.1 (1) requires functional testing 7.9.3.1.1(1) requires functional shall be conducted monthly, with a minimum of 3 testing to be conducted monthly, weeks and a maximum of 5 weeks between tests, with a minimum of 3 weeks and a for not less than 30 seconds and (5) Written maximum of 5 weeks between records of visual inspections and tests shall be tests for not less than 3 seconds kept by the owner for inspection by the authority and 5 written records of visual having jurisdiction. This deficient practice could inspections and tests shall be affect all building occupants. kept by the owner for inspection by the authority having jurisdiction. Findings include: This deficient practice could affect all building occupants. Based on an observation with the Maintenance There were 10 battery powered Director, Administrator, and Director of Property emergency lights throughout the Management on 11/12/24 between 11:15 a.m. and building. Documentation for the 1:00 p.m., there were 10 battery powered monthly 30 second testing for the emergency lights throughout the building. Based batter powered emergency lights on records review at 10:40 a.m., documentation for were not documented for the the monthly 30 second testing for the battery months of February and powered emergency lights were not documented September of 2024. for the months of February and September of POC: 2024. Based on an interview at the time of record All battery powered lights have review and observations, the Maintenance been tested with monthly checks Director stated not all of the required monthly current as of 11/25/24. testing for the emergency battery powered lights All residents could be affected, the were conducted due to there not being a Maintenance Director ensured all Maintenance Director during those times. battery powered lights have been The findings were reviewed with the Any/all residents could be affected Administrator, Director of Property Management, by deficient practice in future, the and Maintenance Director during the exit Maintenance Director ensured all conference. battery-operated lights have been checked with no concerns. Will do 3.1-19(b) checks per schedule. The Administrator will review

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documentation to ensure required testing of battery powered emergency lighting is completed timely monthly x 6 months or until the deficiency is corrected using the attached audit tool. In the

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	Γ OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155176	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/12/2024	
	PROVIDER OR SUPPLIER	TION & SKILLED NURSING CEN	STREET ADDRESS, CITY, STATE, ZIP COD 3811 PARNELL AVE FORT 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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
					event the facility Maintenance Director is an open position of available the Administrator w contact sister facilities for assistance. Date of compliance: 11/26/24	or not ill	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage						
	=/gg-		K 02	293	The facility failed to ensure 1 courtyard doors to the outside the facility were not mistaken facility exit. LSC 7.10.8.3.1 stany door, passage, or stairwathat is neither an exit nor a wexit access and that is locate arranged so that it is likely to mistaken for an exit shall be identified by a sign that reads follows: NO EXIT. The NO Exign shall have the work NO letters 2 inches high, with a swidth of 3/8ths inch, and the EXIT below the word NO, unsuch sign is an approved exit sign. The deficient practice caffect 25 residents on the we side of the building. The west courtyard door whice could be mistaken as an exit to an enclosed courtyard. The door was not provided with a EXIT" sign. POC:	e of as a tates ay ay of d or be s as XIT in troke work less ting ould st ch led e	11/29/2024

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door is not an exit to the public way and did not

The finding was reviewed with the Administrator,

have a "NO EXIT" sign posted.

Director of Property Management, and

Event ID:

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Appropriate signage was ordered

the deficient practice, appropriate

signs have been ordered.

with expected delivery of 11/29/24. 25 residents could be affected by

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155176		A. B	(x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/12/2024	
		TER	3811 P	ARNELL AVE		
(EACH DEFICIEN REGULATORY OR	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
Maintenance Direct 3.1-19(b)	or during the exit conference.			signs have been ordered and be placed upon delivery. The Maintenance Director will check all exit doors for approp signage monthly x 6 months o until the deficiency is corrected using the tool attached. The	will riate r d	
Based on record revoluservation, the fact documentation for to of 48 of 48 battery or resident rooms was 4.6.12.3 states exist to the public, if not maintained. NFPA Tests. Fire-warning and tested in accord published instruction of Chapter 14. NFP testing, and mainter the requirements of equipment manufact This deficient practification. Findings include: Based on observation Director, Administr Management on 11/1:00 p.m., all resides	riew, interview, and illity failed to ensure he preventative maintenance operated smoke alarms in complete. NFPA 101 in ing life safety features obvious required by the Code, shall be 72, 29.10 Maintenance and equipment shall be maintained ance with the manufacturer's ns and per the requirements A 72, 14.2.1.1.1 Inspection, nance programs shall satisfy this Code and conform to the turer's published instructions. ice could affect all residents.	K	0300	maintenance of 48 of 48 batte operated smoke alarms in res rooms was complete. NFPA 1 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the C shall be maintained. NFPA 72 29.10 Maintenance and Tests Fire-warning equipment shall maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. N 72, 14.2.1.1.1 Inspection, testi and maintenance programs sh satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect.	ry ident 01 de , . be IFPA ing, nall s	11/26/2024
F	PROVIDER OR SUPPLIER ROOK REHABILITA SUMMARY: (EACH DEFICIEN REGULATORY OR Maintenance Direct 3.1-19(b) NFPA 101 Protection - Other Based on record rev observation, the fact documentation for t of 48 of 48 battery or resident rooms was 4.6.12.3 states exist to the public, if not maintained. NFPA Tests. Fire-warning and tested in accord published instructio of Chapter 14. NFP testing, and mainter the requirements of equipment manufac This deficient practi Findings include: Based on observation Director, Administr Management on 11/ 1:00 p.m., all reside	DENTIFICATION NUMBER 155176 PROVIDER OR SUPPLIER ROOK REHABILITATION & SKILLED NURSING CEN SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Maintenance Director during the exit conference. 3.1-19(b) NFPA 101 Protection - Other Based on record review, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of 48 of 48 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents.	DENTIFICATION NUMBER 155176 ROOK REHABILITATION & SKILLED NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Maintenance Director during the exit conference. 3.1-19(b) NFPA 101 Protection - Other Based on record review, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of 48 of 48 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents. Findings include: Based on observations with the Maintenance Director, Administrator, and Director of Property Management on 11/12/24 between 11:15 a.m. and 1:00 p.m., all residents' rooms contained battery	DEPROVIDER OR SUPPLIER COCK REHABILITATION & SKILLED NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Maintenance Director during the exit conference. 3.1-19(b) NFPA 101 Protection - Other Based on record review, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of 48 of 48 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents. Findings include: Based on observations with the Maintenance Director, Administrator, and Director of Property Management on 11/12/24 between 11:15 a.m. and 1:00 p.m., all residents' rooms contained battery	PROVIDER OR SUPPLIER ROOK REHABILITATION & SKILLED NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR I.S.: IDENTIFYING INPORMATION Maintenance Director during the exit conference. 3.1-19(b) Maintenance Director during the exit conference. 3.1-19(b) NFPA 101 Protection - Other Based on record review, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of 4.8 of 48 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions and per the requirements of this Code and conform to the equipment manufacturer's published instructions with the Maintenance Director, Administrator, and Director of Property Management on 11/12/24 between 11:15 a.m. and 1:00 p.m., all residents' rooms contained battery STREET ADDRESS, CITY, STATE, ZIP COD 38311 PARNELL AVE FORT WAYNE, IN 46805 FORT WAYNE, IN 46805 FORT WAYNE, IN 46805 TO STREET ADDRESS, CITY, STATE, ZIP COD 38311 PARNELL AVE FORT WAYNE, IN 46805 FORT WAYNE, IN 46805 To assure consumers and feact of the found that the found state of the coords and safe affected in the future appropriation of the prevention of the prev	OF CORRECTION DESTIFICATION NUMBER 155176 STREET ADDRESS, CITY, STATE, ZIP COD 3811 PARNELL AVE FORT WAYNE, IN 46805 SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRICEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Maintenance Director during the exit conference. 3.1-19(b) Maintenance Director during the exit conference. 3.1-19(b) NFPA 101 Protection - Other Based on record review, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of 48 of 48 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 2.9 10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14, NFPA 72, 14.2.1.1.1 inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions and per the requirements of Director, Administrator, and Director of Property Management on 11/1/224 between 11:15 a.m. and 1:00 p.m., all residents' rooms contained battery STREET ADDRESS, CITY, STATE, ZIP COD 3811 PARNELL AVE FORT WAYNE, IN 46805 TO RETURN AVEX TO A STATE THE TOTAL THE CONTRIBUTION AND CORD STATE THE COORS MICROLL AVEX TO CORD STATE THE COORS MICROLL AVEX TO COORS THE COORS MICROLL AVEX TO A STATE THE COORS MICROLL AVEX TO COORS THE CO

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GLENBR	ROVIDER OR SUPPLIER	TION & SKILLED NURSING CEN	ΓER	3811 P	ADDRESS, CITY, STATE, ZIP COD ARNELL AVE 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)		(X5) COMPLETION DATE
K 0324	at 10:15 a.m., the man requires weekly test the smoke alarms. The weekly battery produced for the August of 2024. Battery of record review and Maintenance Direct required weekly test smoke alarms were being a Maintenance The findings were and Administrator, Direct required weekly test smoke alarms were being a Maintenance of the findings were and the	tor stated not all of the ting for the battery powered conducted due to there not be Director during those times.			All residents' rooms contained battery powered smoke alarms. The manufacturer's document requires weekly testing and monthly cleaning of the smoke alarms. No testing documentate for the weekly battery powered smoke alarms was documented for the months of September at August 2024. POC: All battery powered smodetectors are current with weet testing as of 11/25/24. The deficient practice could af all residents, the Maintenance Director ensured all battery powered smoke detectors have been checked with no concern To ensure no residents are affected in the future the Maintenance Director ensured testing is current, and will perfect testing is current, and will perfect tests per schedule. The Administrator will review documentation weekly x 4 week and monthly x 6 months or untit the deficiency is corrected using the attached audit tool. In the event the facility Maintenance Director is an open position or available the Administrator will contact sister facilities for assistance. All battery powere smoke detectors are current weekly testing. Date of compliance: 11/26/24	s. ation etion d ed and oke kly fect e as. all form ot l	
SS=C Bldg. 01	NFPA 101 Cooking Facilities						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155176		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/12/2024		
NAME OF I	PROVIDER OR SUPPLIE	D			ADDRESS, CITY, STATE, ZIP COD	•	
					PARNELL AVE		
GLENBF	ROOK REHABILITA	TION & SKILLED NURSING CEN	ITER	FORT	WAYNE, IN 46805		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` ·			PREFIX (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A		ATF.	COMPLETION
TAG				TAG	DEFICIENCY)		DATE
	Based on observation, records review, and		K 0	324	The facility failed to properly i	nstall	11/26/2024
		ity failed to properly install and			and maintain equipment prote	ected	
		t protected by 1 of 1 kitchen			by 1 of 1 kitchen hood		
		systems. LSC 9.2.3 states			extinguishing systems. LSC 9		
		shall be in accordance with			states cooking equipment sha	ıll be	
		6 section 12.1.2.2 states cooking			in accordance with NFPA 96.		
		g protection shall not be			NFPD 96 section 12.1.2.2 sta	tes	
	moved, modified, or rearranged without prior				cooking appliances requiring		
	re-evaluation of the fire-extinguishing system by				protection shall not be moved		
the system installer or servicing agent, unless				modified, or rearranged witho	ut		
		by the design of the fire			prior re-evaluation of the		
		em, unless such installations			fire-extinguishing system by the	ne	
		ng installations, which shall be			system installer or servicing		
	permitted to be continued in service, and have an				agent, unless otherwise allow		
	approved method that would ensure that the				by the design of the extinguis	-	
	appliances were returned to an approved design location after they had been moved for				system, unless such installation		
		leaning. Section 10.1.2 states			are approved existing installar		
		that produces grease-laden			which shall be permitted to be continued in service, and have		
		ght be a source of ignition of			approved method that would	e an	
		grease removal device, or duct			ensure that the appliances we	vro.	
	_	by fire-extinguishing			returned to an approved design		
	_	eficient practice affects staff in			location after they had been	J 11	
		residents in the main dining			moved for maintenance. And		
	room.	- condense in the main dining			cleaning. Section 10.2.2 state	s	
					cooking equipment that produ		
	The findings include	le:			grease-laden vapors and that		
					might be a source of ignition of		
	Based on records re	eview with the Maintenance			grease in the hood, grease		
	Director and Admir	nistrator on 11/12/24 at 11:10			removal device, or duct shall	be	
	a.m., the kitchen ed	quipment policy indicated all			protected by fire-extinguishing		
	cooking equipment	shall be put back in the			equipment. This deficient pract	ctice	
	designed location b	y aligning the cooking			affects staff in the kitchen and	l all	
		markings on the floor. Based			residents in the main dining re	om.	
		1:59 a.m., all cooking			The kitchen equipment policy		
	equipment in the main kitchen was covered by the				indicated all cooking equipme		
	fire suppression system, but was not provided				shall be put back in the design	ned	
	_	he floor according to the			location by aligning the cooking		
		ensure cooking appliances were			equipment shall be put back i	n the	
	returned to the appr	roved design location after			designed location by aligning	the	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155176	A. B	MULTIPLE CO UILDING /ING	onstruction 01	COMP	E SURVEY PLETED 2/2024
	PROVIDER OR SUPPLIEI	TION & SKILLED NURSING CEN	NTER	3811 P	ADDRESS, CITY, STATE, ZIP CO ARNELL AVE WAYNE, IN 46805	D	_
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	CCTION ULD BE PROPRIATE	(X5) COMPLETION DATE
	cleaning. Based on observation and reconstructor and Direct stated there was a vequipment, but the to ensure cooking a approved design lomoved for maintent. The finding was reported to the property of Property.	ed for maintenance and an interview during cords review, the Maintenance cor of Property Management written policy for cooking floor did not contain markings appliances were returned to an ecation after they had been ance and cleaning. Wiewed with the Administrator, by Management, and tor during the exit conference.			cooking equipment with markings on the floor. Al equipment in the main we covered by the fire supp system but was not prove the markings on the flood according to the facility's ensure cooking appliance returned to the approved location after they had be moved for maintenance cleaning. There is a writt for cooking equipment, a floor did not contain marensure cooking appliance returned to an approved location after they had be moved for maintenance cleaning. POC: The Maintenance Direct marked the designed location after they had be moved for maintenance cleaning. POC: The Maintenance Direct marked the designed location after they had be moved for maintenance cleaning. POC: The Maintenance Direct marked the designed location and the sident practice contains and the sidents, the Maintenance Director has marked the location of the cooking equipment of the cooking exists bright colored tape. To ensure no staff or result affected in the future the Maintenance Director materials and will monitor routinely ensure placement. The Maintenance Direct monitor kitchen equipment with bright colored tape. The Maintenance Director materials and will monitor routinely ensure placement. The Maintenance Direct monitor kitchen equipment monthly x 6 months or under the maintenance placement.	Il cooking //as ression rided with r s policy to ees were d design een and ten policy out the rkings to ees ere design een and or has cation of g bright ould affect d all nce designed equipment sidents are earked the hen plored tape y to or will ent	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED	
		155176	B. WI	NG		11/12	
					_		-
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
a			3811 PARNELL AVE				
GLENBROOK REHABILITATION & SKILLED NURSING CE				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
					deficiency is corrected using t	he	
					attached audit tool to ensure a		
					kitchen equipment is clearly		
					marked with design location to)	
					ensure corrected placement if		
					moved. Please see attached		
					pictures.		
					Date of compliance: 11/26/24		
K 0353	NFPA 101						
SS=F	Sprinkler System -	- Maintenance and Testing					
Bldg. 01		•					
	Based on record rev	view and interview, the facility	K 0.	353	The facility failed to maintain	1 of 1	11/26/2024
	failed to maintain 1	of 1 sprinkler system in			sprinkler system in accordance		
	accordance with LS	C 9.7.5. LSC 9.7.5 requires all			with LSC 9.7.5. LSC 9.7.5		
	automatic sprinkler	systems shall be inspected			requires all automatic sprinkle	er	
	and maintained in a	ccordance with NFPA 25,			systems shall be inspected ar		
	Standard for the Ins	pection, Testing, and			maintained in accordance with	า	
	Maintenance of Wa	ter-Based Fire Protection			NFPA 25, Standard for the		
	Systems. NFPA 25	, 2011 edition, Table 5.1.1.2			Inspection. Testing, and		
	indicates the require	ed frequency of inspection and			Maintenance of Water-Based	Fire	
	testing. NFPA 25, 5	5.2.4.1 states gauges on wet			Protection Systems. NFPA 25	j,	
	pipe sprinkler syster	ms shall be inspected monthly			5.2.4.1 edition, Table 5.1.1.2		
	and gauges on dry s	systems (5.2.4.2) shall be			indicates the required frequen	icy of	
	inspected weekly to	ensure normal water or air			inspection and testing. NFPA	-	
	pressure is being ma	aintained. NFPA 25 13.3.2.1			5.2.4.1 states gauges on wet	pipe	
	states valves should	be inspected weekly or			sprinkler systems shall be		
	valves secured locks	s or supervised (13.3.2.1.1)			inspected monthly and gauge	s on	
	shall be permitted to	be inspected monthly. This			dry systems (5.2.4.2) shall be		
	deficient practice co	ould affect all occupants.			inspected weekly to ensure		
					normal water or air pressure is	s	
	Findings include:				being maintained. NFPA 25		
					13.3.2.1 states valves should	be	
	Based on records re	view with the Maintenance			inspected weekly or valves		
	Director and the Ad	lministrator on 11/12/24 at			secured locks or supervised		
	10:13 a.m., the follo	owing required sprinkler system			(13.3.2.1.1) shall be permitted	l to	
	inspections were no	t completed:			be inspected monthly. This		
	a). There were no w	veekly inspections of the dry			deficient practice could affect	all	
		m's pressure gauges for the			occupants.		
		, August, and September of			There were no weekly inspect	tions	

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CE.TERD I OI	THE CONTROL OF THE CO	THE SELL TODA				0	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) N	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPI	LETED
		155176		ING		I	/2024
		100170				1 1/ 12	12027
NAME OF I	PROVIDER OR SUPPLIER	D		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	ROVIDER OR SUPPLIER	N.		3811 P	ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CEN	NTER	FORT V	WAYNE, IN 46805		
(VA) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIE		ı	ID.	Ī		(V5)
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	2024.				of the dry sprinkler system's		
		monthly inspections of the dry			pressure gauges for the month	hs of	
	pipe sprinkler syste	em's control valves for the			February, August, and Septen	nber	
	months of January	and September of 2024 and			of 2024.		
	December of 2023.				There were no monthly		
	During an interview	w at the time of record review,			inspections of the dry pipe		
	the Maintenance Di	irector stated not all of the			sprinkler system's control valu	ies	
	required inspection	s for the gauges and valves			for the months of January and		
		e to there not being a			September of 2024 and Decei		
		tor during those times.			of 2023.		
					POC:		
	The finding was rev	viewed with the Administrator,			The Maintenance Director ens	sured	
	_	y Management, and			all testing/inspections are curr		
		tor during the exit conference.			All occupants could be affecte		
	With the state of	tor daring the exit conference.			this deficient practice. The	a by	
	3.1-19(b)				Maintenance Director ensured	الد ا	
	3.1 17(0)				testing/inspections are current		
					To ensure no occupants are	١.	
					affected in the future the		
					Maintenance Director ensured	ااما	
					testing/inspections current, wi	II	
					perform test/inspections per		
					schedule.		
					The Administrator will review		
					documentation to ensure week	KIY	
					and monthly checks are		
					completed weekly x 4 weeks,		
					monthly x 6 months or until the		
					deficiency is corrected using t		
					attached audit tool. In the eve		
					the Maintenance Director posi		
					is an open position or not avai	ilable	
					the Administrator will contact		
					sister facilities for assistance.		
					Date of compliance: 11/26/24		
K 0355	NFPA 101						
SS=E	Portable Fire Exti	nguishers					
Blda 01	l						

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Based on observation and interview, the facility

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K 0355

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The facility failed to ensure 2 of 4

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11/26/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES									
CENTERS FOR MEDICARE & MEDICAID SERVICES									
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION							

X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLETED 155176 B. WING 11/12/2024 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 failed to ensure 2 of 4 portable fire extinguishers in portable fire extinguishers in the the basement were given maintenance at periods basement were given maintenance not more than one year apart. NFPA 10, the at periods not more than one year Standard for Portable Fire Extinguishers, at apart. NFPA 10, the Standard for Section 7.3.1.1.1 requires that fire extinguishers Portable Fire Extinguishers, at shall be subjected to maintenance at intervals of Section 7.3.1.1.1 requires that fire not more than 1 year, at the time of hydrostatic extinguishers shall be subjected test, or when specifically indicated by an to maintenance at intervals of not inspection or electronic notification. Section more than 1 year, at the time of 3.3.15 defines extinguisher maintenance as a hydrostatic test or when thorough examination of the fire extinguisher that specifically indicated by is intended to give maximum assurance that a fire inspection or electronic extinguisher will operate effectively and safely notification. Section 3.3.15 defines and to determine if physical damage or condition extinguisher maintenance as a will prevent its operation, if any repair or thorough examination of the fire replacement is necessary, and if hydrostatic extinguishers that is intended to testing or internal maintenance is required. give maximum assurance that a Section 7.3.3 states each fire extinguisher shall fire extinguisher will operate have a tag or label securely attached that effectively and safely and to indicates the month and year the maintenance was determine if physical damage or performed, identifies the person performing the condition will prevent it's work, and identifies the name of the agency operation, if any repair or performing the work. This deficient practice could replacement is necessary, and if staff in the basement. hydrostatic testing or internal maintenance is required. Section Findings include: 7.3.3 states each fir extinguisher shall have a tag or label securely Based on observation with the Maintenance attached that indicates the month Director, Director of Property Management, and and year the maintenance was the Administrator on 11/12/24 at 12:03 p.m., the performed, identifies the person tags on two of the fire extinguishers in the performing the work, and identifies basement had an annual inspection date of May the name of the agency performing 2023 while all other fire extinguishers in the the work. The deficient practice basement had an inspection date of May 2024. could affect the staff in the Based on an interview during observations, the basement. Maintenance Director stated it is most likely the The tags on two of the fire two extinguishers were missed during the annual extinguishers in the basement had inspection. an annual inspection date of May 2023 while all other fire The finding was reviewed with the Administrator, extinguishers in the basement had

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	JILDING	01	COMPL	
		155176	B. W	ING		11/12/	/2024
	PROVIDER OR SUPPLIE	R ATION & SKILLED NURSING CEN	ITER	3811 P	ADDRESS, CITY, STATE, ZIP COD PARNELL AVE WAYNE, IN 46805		
	TOOK KENABIENA	THOM & GRIELED NORGING GEN		TOKI	WATNE, IN 40005		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	•	ty Management, and			an inspection date of May 202		
	Maintenance Direc	etor during the exit conference.			POC: The Maintenance Direct	ior	
	2.1.10(1)				contacted Whitlock's for		
	3.1-19(b)				inspection. The 2 fire	l	
					extinguishers were inspected	-	
					Whitlock's with tags updated of 11/21/24.	Ж	
					The deficient practice could at	ffect	
					all staff in the basement, the	1001	
					Maintenance Director contacte	ed	
					Whitlock's for service/inspection		
					Inspection was completed on		
					11/21/24		
					To ensure no staff are affected	d in	
					the future the Maintenance		
					Director will ensure inspection	with	
					scheduled monthly tasks and		
					report any concerns to the		
					Administrator.		
					The Administrator will review		
					documentation monthly x 6		
					months using the attached au		
					tool to ensure compliance. Cu		
					deficiency corrected on 11/21	24.	
					Please see attached documentation.		
					Date of compliance: 11/26/24		
					Date of compliance. 11/20/24		
K 0372	NFPA 101						
SS=E		illding Spaces - Smoke					
Bldg. 01	Barrie						
	Based on observati	ion and interview, the facility	K 0	372	The facility failed to ensure		11/26/2024
		netrations through 1 of 6 smoke			penetrations through 1 of 6 sn	noke	
		protected to maintain the smoke			barrier walls were protected to)	
		smoke barrier. LSC Section			maintain the smoke resistance		
	_	moke barriers to be constructed			each smoke barrier. LSC Sec		1
		LSC Section 8.5 and shall have			19.3.7.5 requires smoke barrie		
		r fire resistive rating. LSC			be constructed in accordance		
		uires smoke barriers to be			LSC Section 8.5 and shall have		
	continuous from ar	n outside wall to an outside			minimum ½ hour fire resistive		

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CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPI	LETED
		155176	B. W	'ING		11/12	/2024
NAME OF	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
CI ENDE		TION & SKILLED NUBSING CEN	ITED		WAYNE, IN 46805		
GLEND	ROOK REHABILITATION & SKILLED NURSING CENTE		HER	FURT			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1	o a floor, or from a smoke barrier			rating. LSC Section 8.5.2.1		
	to a smoke barrier,	or by use of a combination			requires smoke barriers to be		
	thereof. 8.5.6.2 red	quires penetrations for cables,			continuous from an outside wa	all to	
	cable trays, conduit	ts, pipes, tubes, vents, wires,			an outside wall, from a floor to	а	
		o accommodate electrical,			floor, or from a smoke barrier t	to a	
	_	ing, and communications			smoked barrier, ir by use of		
	1 *	nrough a wall, floor, or			combination there of. 8.5.6.2		
		bly constructed as a smoke			requires penetrations for cable	es,	
	barrier, or through	the ceiling membrane of the			cable trays, conduits, pipes,		
	roof/ceiling of a sm	noke barrier assembly, shall be			tubes, vents, wires, and simila	r	
	protected by a syste	em or material capable of			items to accommodate electric	al,	
	restricting the move	ement of smoke. This deficient			mechanical, plumbing, and		
	practice could affect	ct staff and at least 30 residents			communications systems that		
	in two smoke comp	partments.			pass through a wall, floor, or		
					floor/ceiling assembly construc	cted	
	Findings include:				as a smoke barrier, or through	а	
					ceiling membrane of the		
	Based on observati	on with the Maintenance			roof/ceiling of a smoke barrier		
	Director, Administ	rator, and Director of Property			assembly, shall be protected b	y a	
	Management, on 1	1/12/24 at 12:30 p.m., in the attic			system or material capable of		
	of the two-hour fire	e wall which was being used as			restricting the movement of		
	a smoke barrier by	room 301 had a 6-inch gap			smoke. This deficient practice		
	around a pipe. Base	ed on an interview at the time			could affect staff and at least 3	30	
	of observation, the	Maintenance Director agreed			residents in two smoke		
	there was an unseal	led penetration in the			compartments.		
	fire/smoke barrier b	by room 301.			In the attic of the two-hour fire	wall	
					which was being used as a sm	noke	
	1	viewed with the Administrator,			barrier by room 301 had a 6-in	ıch	
		y Management, and			gap around a pipe.		
	Maintenance Direc	tor during the exit conference.			POC:		
					Fire Wall repaired using fire ca	aulk	
	3.1-19(b)				on 11/25/24		
					At least 30 residents could be		
					affected by the deficient practi		
					gap in fire wall was repaired us	sing	
					fire caulk		
					To ensure no residents are		
					affected in the future the		

Maintenance Director will inspect

all fire walls monthly.

DEPARTMENT OF HEALTH AND HUN	IAN SERVICES							
ENTERS FOR MEDICARE & MEDICAID SERVICES								
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION						

	OF CORRECTION	IDENTIFICATION NUMBER 155176		JILDING	01	COMPL 11/12/	ETED
	ROVIDER OR SUPPLIER	FION & SKILLED NURSING CENT	ER	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 APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
					The Maintenance Director will inspect all fire walls monthly x months or until deficiency ensuring there are no areas the would allow penetration using tool attached. Please see attached pictures. Date of compliance: 11/26/24	at	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and	Electric					
	failed to ensure 2 of hall nurses' station of was protected from Edition. Article 406 (Cover Plates), required be installed so as to and seat against the 2011 Edition. Article Receptacles shall be terminals are not extended to the deficient practice control of the deficient pra	on and interview, the facility 2 electrical outlets in the 100 contained a cover plate and damage. NFPA 70, 2011 .6, Receptacle Faceplates ires receptacle faceplates shall completely cover the opening mounting surface. NFPA 70, e 406.5 (F) Exposed Terminals, e enclosed so that live wiring posed to contact. This build affect 20 residents in the contact in the cont	KO	511	The facility failed to ensure 2 of electrical outlets in the 100 hall nurses' station contained a couplate and was protected from damage. NFPA 70, 2011 Edition Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening a seat against the mounting surfour NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed that live wiring terminals are not exposed to contact. The deficit practice could affect 20 resider in the 100 hall. In the 100 hall nurses' station backroom there were two electrical outlets with missing cover plates. POC: The Maintenance Director installed plate covers on the two electrical outlets in 100 hall nurses' station backroom. 20 residents could be affected the deficient practice, the plate	I ver on. and ace. so ot ent ents	11/26/2024

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ENTERS FOR MEDICARE & MEDICA	AID SERVICES		ONID 110: 0750-057
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>	COMPLETED
	155176	B. WING	11/12/2024

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 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 DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Maintenance Director during the exit conference. covers were installed on 2 outlets, all other outlets were inspected for 3.1-19(b)broken/missing plate covers. To ensure no residents are affected in the future the Maintenance Director will inspect all outlets for broken/missing plate covers. The Maintenance Director will inspect all outlets monthly x 6 months or until deficiency is corrected using the attached tool. Please see attached documentation/pictures. Date of compliance: 11/26/24 K 0741 **NFPA 101** SS=E **Smoking Regulations** Bldg. 01 Based on observation and interview, the facility K 0741 11/26/2024 The facility failed to ensure 2 of 2 failed to ensure 2 of 2 smoking areas were smoking areas were maintained maintained by disposing cigarette butts in a metal by disposing cigarette butts in a or noncombustible container with self-closing metal or noncombustible container cover devices. This deficient practice could affect with self-closing cover devices. staff and 10 residents in the courtyard. The deficient practice could affect staff and 10 residents in the Findings include: courtyard. Outside the employee exit behind Based on observation with the Maintenance the dumpsters there were over 15 Director on 11/12/24 between 9:00 a.m. and 1:00 cigarette butts disposed on the p.m., the following cigarette butts were not ground inside and outside of the properly disposed: staff smoking area. In the a.) Outside the employee exit behind the courtyard resident's smoking area dumpsters there were over 15 cigarette butts there were over 15 cigarette butts disposed on the ground inside and outside of the disposed on the ground. staff smoking area. POC: b.) In the courtyard resident's smoking area there Cigarette Butts were cleaned up were over 15 cigarette butts disposed on the and disposed of properly. The deficient practice could affect Based on an interview at the time of observations, staff and 10 residents in the

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155176	B. WI	NG		11/12/	2024
	PROVIDER OR SUPPLIER	TION & SKILLED NURSING CENT	ER	3811 P	ADDRESS, CITY, STATE, ZIP COD ARNELL AVE WAYNE, IN 46805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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 APPROPRIA DEFICIENCY)	.IE	DATE
	cigarette butts on th areas. The findings were r Administrator, Dire	rector agreed there were e ground in both smoking eviewed with the ctor of Property Management, irector during the exit			courtyard. Cigarette butts were cleaned up and disposed of properly, all staff were in-servi on smoking policies. To ensure no staff or residents affected in the future all staff vin-serviced on 11/13/24, the Maintenance Director will do drounds and spot checks to ensul cigarette butts are disposed	ced s are vere laily sure	
K 0918	NFPA 101				properly. The Maintenance Director will ensure appropriate receptacle available for disposal of cigare butts. The Administrator will a weekly x 4 weeks then monthl times 6 months or until deficie corrected using attached audit tool. Date of compliance: 11/26/24	es are ette udit y ncy	
SS=C Bldg. 01	Based on record reversal failed to ensure a warminspections for the graph of 12 of 52 weeks and 3 of 12 months. Note that the second of 12 months is shall be a NFPA 110, Standar Power Systems. Note that the second of 12 months including all appurtance of 130 minutes. NFPA 12 record of inspections.	riew and interview, the facility ritten record of weekly generator was maintained for a 30-minute run under load for FPA 99, 6.4.4.1.3 requires onsite maintained in accordance with d for Emergency and Standby FPA 110, 8.4.1 requires an Supply System (EPSS) enant components, shall be and exercised monthly. 110 8.4.2 rator sets in service to be accementally, for a minimum of 699, 6.4.4.2 requires a written at performance, exercising for the generator to be	K 09	918	The facility failed to ensure a written record of weekly inspections for the generator waintained for 12 of the 52 we and a 30-minute run under load of 12 months. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained accordance with NFPA 110., Standard for Emergency and Standby Power Systems. NFF 110, 8.4.1 requires an Emerge Power Supply Systems (EPSS including all appurtenant components, shall be inspected weekly and exercised monthly	eeks ad for d in PA ency S)	11/26/2024

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PRINTED: 12/05/2024 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLETED 155176 B. WING 11/12/2024 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 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	regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on records review with the Maintenance Director and the Administrator on 11/12/24 at 10:00 a.m., The diesel generator lacked the following required testing: a.) Weekly inspections for the months of March, August, and September of 2024. b.) Monthly load testing for the months of February, March, and September of 2024. Based on an interview at the time of record review, the Maintenance Director stated some of the weekly generator inspections and monthly load testing were missed due to no Maintenance Director during the aforementioned times. The finding was reviewed with the Administrator, Director of Property Management, and Maintenance Director during the exit conference. 3.1-19(b)	TAG	110 8.4.2 requires emergency generator sets in service to be exercised once monthly, for a minimum of 30 minutes. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff, and visitors. The diesel generator lacked weekly inspections for the months of March, August, and September of 2024, Monthly load testing for the months of February, March, and September of 2024. POC: Weekly and Monthly checks are current as of 11/25/24. The deficient practice could affect all residents, staff, and visitors. The Maintenance Director ensured all weekly and monthly checks are current with no concerns. To ensure no residents, staff, or visitors are affected in the future the Maintenance Director has ensured all weekly/monthly checks are current. Will conduct and document weekly/monthly checks per schedule. The Administrator will review documentation to ensure all tasks are completed timely weekly x 4 weeks then monthly x 6months or until deficiency is corrected using	DATE

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DEPARTMENT OF HEALTH AND HUMAN SE	RVICES	
CENTERS FOR MEDICARE & MEDICAID SEF	RVICES	

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155176	` ′	ILDING	onstruction 01	(X3) DATE COMPL 11/12	ETED
	PROVIDER OR SUPPLIER	TION & SKILLED NURSING CENT	ER	3811 P	ADDRESS, CITY, STATE, ZIP COD ARNELL AVE NAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B. CROSS-REFERENCED TO THE APPROPE TAG DEFICIENCY)		TE	(X5) COMPLETION DATE	
					event the facility Maintenance Director is an open position or available the Administrator wil contact sister facilities for assistance. Date of compliance 11/26/24.	not	

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