PRINTED: 04/30/2025 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 <u>00</u>		COMPLETED				
155176		155176	B. WING		04/10/2025				
			CTDEET	TADDRESS CITY STATE 710 COD					
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 3811 PARNELL AVE								
GLENBR	ROOK REHABII ITA	TION & SKILLED NURSING CE		WAYNE, IN 46805					
	1								
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI	(X5)				
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPE	RIATE				
TAG F 0000	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	Dia relative i	DATE				
F 0000									
Bldg. 00									
Blug. 00	This visit was for the Investigation of Complaints		F 0000	Facility respectfully requests					
		0456068 and IN00457158.	1 0000	paper compliance					
	11.00.10072, 11.00.10000 4114 11.00.107100			Paper sampling					
	Complaint IN0045	5072- No deficiencies related to							
	the allegations are	cited.							
		6068 - Deficiencies related to the							
	allegations are cite	d at F602.							
	C 1 : 4 D10045	7150 N. 16 14 14							
	the allegations are	7158 - No deficiencies related to							
	the anegations are	cited.							
	Survey date: April	10 2025							
		10, 2020							
	Facility number: 0	00092							
	Provider number:	155176							
	AIM number: 1002	266090							
	Census Bed Type:								
	SNF/NF: 50								
	Total: 50								
	Conque Dayor Type								
	Census Payor Type: Medicare: 2								
	Medicaid: 44								
	Other: 4								
	Total: 50								
	This deficiency ref	lects State Findings cited in							
	accordance with 4	10 IAC 16.2-3.1.							
	Quality review cor	npleted April 11, 2025							
L 0600	400.40								
F 0602 SS=D	483.12	propriation/Evaloitation							
Bldg. 00	Free from Misapp	propriation/Exploitation							
Diag. 00	Based on interview	and record review, the facility	F 0602	F 602	04/22/2025				
	Dased on micrylew		1 0002	1 002	<u> </u>				
LABORATOR	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE				
Jamie Solo	omon		ED		04/24/2025				

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: UN4F11 Facility ID: 000092 If continuation sheet Page 1 of 4

PRINTED: 04/30/2025 FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039							
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING 00		00	COMPLETED	
155176		B. W	ING		04/10/2025		
				CTREET	ADDRESS CITY STATE TIP SOD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
OLENDE	OOK DELIABILITA	TION & OZULLED NUIDOING CEN	JTED		ARNELL AVE		
GLENBR	OOK REHABILITA	TION & SKILLED NURSING CEN	NIEK	FURI	WAYNE, IN 46805		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	J	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APP		E	COMPLETION
TAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	DATE	
	failed to the ensure	residents were free from					
	misappropriation of property for 1 of 5 residents reviewed (Resident B).				What corrective action(s) wi	ll be	
					accomplished for those resid	dents	
					-	o have been affected by the	
	Findings include:				deficient practice;	·	
					Resident B no longer re	sides	
	Resident B's record	was reviewed on 4/10/25 at			in the facility.		
	12:45 PM. Residen	t B no longer resided in the			Misappropriated funds v	were	
	facility.				replaced by the facility.		
	-				How other residents having	the	
	A report, dated 3/24	1/25, provided by the			potential to be affected by the		
	Administrator on 4/10/25 at 12:42 PM indicated Certified Nurse Aide (CNA) 3 was suspected of theft.				same deficient practice will I		
					identified and what correctiv		
					action(s) will be taken;		
					All residents that reside	in	
	A file was provided by the Administrator on 4/10/25 at 12:42 PM. The file included the following statements:				the facility have the potentia	I to be	
					affected.		
					All staff in-serviced on A	Abuse	
					Prohibition Policy, specific to)	
	Housekeeping Supervisor's statement, dated 3/25/25, indicated Housekeeping Aide 4 reported an allegation of theft on 3/23/25. The statement indicated Housekeeping Aide 4, on 3/19/25, observed CNA 3 search the pockets of Resident B's clothes, found his wallet and removed \$27 of cash. Housekeeping Aide 4's statement, dated 3/24/25,				misappropriation per ED/De	signee	
					by 4/19/25.	_	
					All resident interviews v	vere	
					completed for any missing it	ems.	
					What measures will be put in		
					place or what systemic char	nges	
					will be made to ensure that	the	
					deficient practice does not re	ecur;	
					All staff in-serviced on A		
	indicated she obser	ved CNA 3 search the pockets			Prohibition Policy, specific to)	
	of Resident B's clot	hes, found a wallet with \$27 of			misappropriation, per		
	cash. Housekeeping	g Aide 4 indicated CNA 3			ED/Designee by 4/19/25.		
	asked if there were	any cameras in the laundry			All staff will receive Abu	ise	
	room. Housekeeping Aide 4 indicated she was unaware of any cameras. Housekeeping Aide 4 then indicated CNA 3 indicated "I can use this				in-servicing annually via reli	as.	
					Abuse reminders will be		
					completed in bi-monthly all s	staff	
	money for gas," the	en observed CNA 3 put the \$27			in-services		
	cash in her pocket.	-			All new hired staff will re	eceive	
	*				abuse in-servicing during		

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

An Administrator and Housekeeper Supervisor

statement, dated 3/24/25, indicated CNA 3 was

Event ID:

UN4F11

Facility ID: 000092

orientation.

If continuation sheet

How the corrective action(s) will be

Page 2 of 4

PRINTED: 04/30/2025 FORM APPROVED OMB NO. 0938-039

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. BU	A. BUILDING <u>00</u>		COMPLETED	
155176		155176	B. WING			04/10/	2025
STREET ADDRESS, CITY, STATE, ZIP COD							
NAME OF PROVIDER OR SUPPLIER							
GLENBROOK REHABILITATION & SKILLED NURSING CENT			3811 PARNELL AVE FORT WAYNE, IN 46805				
GLENDR	OUR REHABILITA	TION & SKILLED NORSING CENT	EK	FORT	VATNE, IN 40005		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	F	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	interviewed by the	Administrator and the			monitored to ensure the deficie	ent	
	Housekeeping Supe	ervisor on 3/24/25. The			practice will not recur, what qu	ality	
	statement indicated	CNA 3 searched the pockets			assurance program will be put	into	
	of Resident B's clot	hes but denied the allegation			place;		
	of taking Resident I	B's money out of his wallet.			Ongoing compliance with this corrective action will be monitored		
	In an interview, on	4/10/25 at 12:38 PM, CNA 2			via facility QAPI program, with		
	indicated personal is	tems, including money should			meetings being held bi-monthly	y,	
	be not taken from a	resident. CNA 2 indicated			and is overseen by the Execut	ive	
	when stealing was o	observed, she reported the			Director.		
	incident to the Direct	ctor of Nursing (DON) and/or			CQI tool identified as F 60	2	
	the Administrator. C	CNA 2 indicated if neither the			will be completed weekly x 4		
	DON or Administra	tor were available, she would		weeks, monthly times 6 months,		s,	
	report to the Charge Nurse.				and quarterly thereafter until		
					compliance is achieved.		
	A policy, undated, titled "Abuse: Zero				If threshold of 100% is not		
	Tolerance," was provided by the Administrator on				met, an action plan will be		
	4/10/25 at 12:42 PM. The policy indicated taking or				developed to ensure complian	ce.	
	borrowing money from a resident was considered						
	a form of abuse. The policy indicated the facility				By what date the systemic		
	had a zero tolerance of any form of abuse.				changes will be completed;		
					4/22/2025		
	This finding relates to Complaint IN00456068.						
					F		
	3.1-28(a)						
					What corrective action(s) will b	е	
					accomplished for those reside	nts	
					found to have been affected by		
					deficient practice;		
					All staff in-serviced on ab	use	
					and misappropriation, CQI tool		
					completed per schedule		
					How other residents having the	e	
					potential to be affected by the		
					same deficient practice will be		
					identified and what corrective		
					action(s) will be taken;		
					All staff in-serviced on abu	ıse	
					and misappropriation, CQI tool		

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

Event ID:

UN4F11 Facility ID: 000092

If continuation sheet Page 3 of 4

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

PRINTED: 04/30/2025 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 <u>00</u>		00	COMPLETED	
155176		155176	B. WING			04/10/2025	
NAME OF PROVIDER OR SUPPLIER GLENBROOK REHABILITATION & SKILLED NURSING CENTE			STREET ADDRESS, CITY, STATE, ZIP COD 3811 PARNELL AVE FORT WAYNE, IN 46805				
(X4) ID	e) ID SUMMARY STATEMENT OF DEFICIENCIE			ID	T		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		IE	DATE
					completed per schedule, custo care rounds	omer	
					What measures will be put into		
					place or what systemic change will be made to ensure that the		
					deficient practice does not rec		
					All staff in-serviced on ab		
				and misappropriation, CQI tool			
					completed per schedule		
					How the corrective action(s) we monitored to ensure the defici practice will not recur, what que assurance program will be put place; Ongoing compliance with corrective action will be monitorially facility QAPI program, with meetings being held bi-month and is overseen by the Executive Director. CQI tool identified as will completed weekly x 4 weeks,	ent uality t into this ored l ly, tive	
					monthly times 6 months, and quarterly thereafter until compliance is achieved.		
					If threshold of 100% is no	ot	
					met, an action plan will be		
					developed to ensure complian	ice.	
					By what date the systemic changes will be completed; 4/22/25		

Event ID: UN4F11 Facility ID: 000092 Page 4 of 4 If continuation sheet