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	04/10/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00455072, IN00456068 and IN00457158. Complaint IN00455072- No deficiencies related to the allegations are cited. Complaint IN00456068 - Deficiencies related to the allegations are cited at F602. Complaint IN00457158 - No deficiencies related to the allegations are cited. Survey date: April 10, 2025 Facility number: 000092 Provider number: 155176 AIM number: 100266090 Census Bed Type: SNF/NF: 50 Total: 50 Census Payor Type: Medicare: 2 Medicaid: 44 Other: 4 Total: 50 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 11, 2025	F 0000	Facility respectfully requests paper compliance	
F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation Based on interview and record review, the facility	F 0602	**F 602**	04/22/2025

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

Jamie Solomon | 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.

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	failed to the ensure residents were free from misappropriation of property for 1 of 5 residents reviewed (Resident B). Findings include: Resident B's record was reviewed on 4/10/25 at 12:45 PM. Resident B no longer resided in the facility. A report, dated 3/24/25, provided by the Administrator on 4/10/25 at 12:42 PM indicated Certified Nurse Aide (CNA) 3 was suspected of theft. A file was provided by the Administrator on 4/10/25 at 12:42 PM. The file included the following statements: 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, indicated she observed CNA 3 search the pockets of Resident B's clothes, found a wallet with $27 of cash. Housekeeping Aide 4 indicated CNA 3 asked if there were any cameras in the laundry room. Housekeeping Aide 4 indicated she was unaware of any cameras. Housekeeping Aide 4 then indicated CNA 3 indicated "I can use this money for gas," then observed CNA 3 put the $27 cash in her pocket. An Administrator and Housekeeper Supervisor statement, dated 3/24/25, indicated CNA 3 was		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident B no longer resides in the facility. Misappropriated funds were replaced by the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents that reside in the facility have the potential to be affected. All staff in-serviced on Abuse Prohibition Policy, specific to misappropriation per ED/Designee by 4/19/25. All resident interviews were completed for any missing items. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; All staff in-serviced on Abuse Prohibition Policy, specific to misappropriation, per ED/Designee by 4/19/25. All staff will receive Abuse in-servicing annually via relias. Abuse reminders will be completed in bi-monthly all staff in-services All new hired staff will receive abuse in-servicing during orientation. How the corrective action(s) will be	

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	interviewed by the Administrator and the Housekeeping Supervisor on 3/24/25. The statement indicated CNA 3 searched the pockets of Resident B's clothes but denied the allegation of taking Resident B's money out of his wallet. In an interview, on 4/10/25 at 12:38 PM, CNA 2 indicated personal items, including money should be not taken from a resident. CNA 2 indicated when stealing was observed, she reported the incident to the Director of Nursing (DON) and/or the Administrator. CNA 2 indicated if neither the DON or Administrator were available, she would report to the Charge Nurse. A policy, undated, titled "Abuse: Zero Tolerance," was provided by the Administrator on 4/10/25 at 12:42 PM. The policy indicated taking or borrowing money from a resident was considered a form of abuse. The policy indicated the facility had a zero tolerance of any form of abuse. This finding relates to Complaint IN00456068. 3.1-28(a)		monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held bi-monthly, and is overseen by the Executive Director. CQI tool identified as F 602 will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. If threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; 4/22/2025 **F** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All staff in-serviced on abuse and misappropriation, CQI tool completed per schedule How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All staff in-serviced on abuse and misappropriation, CQI tool	

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			completed per schedule, customer care rounds What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; All staff in-serviced on abuse and misappropriation, CQI tool completed per schedule How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held bi-monthly, and is overseen by the Executive Director. CQI tool identified as will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. If threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; 4/22/25	