STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155176	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenbrook Rehabilitation & Skilled Nursing Center	3811 Parnell Ave Fort Wayne, IN 46805

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure staff followed physician orders for 3 of 3 residents reviewed. (Resident B, Resident C, and Resident D)Findings include: 1. A record review for Resident B began on 11/18/25 at 11:45 AM. Diagnoses included type 2 diabetes, atherosclerosis of the left leg, and right-sided below the knee amputation.A review of Resident B's current quarterly MDS, dated [DATE], indicated their BIMS (Basic Interview for Mental Status) score was 14. (cognitively intact). The MDS indicated the resident received insulin injections 7 days a week. A review of physician orders, dated 9/10/25, indicated 8 units of Humalog insulin was to be administered three times a day with meals. If the blood glucose was less than 150, the insulin dose was not to be given.A review of physician orders, dated 9/2/25, indicated blood glucose was to be measured and recorded four times a day, before meals and at bedtime.A review of the Medication Administration Record (MAR), dated 9/1/25-9/30/25, indicated Resident B was given 8 units of insulin on 9/11/25 at 6:00 PM for a blood sugar less than 150 and 9/17/25 at noon for a blood sugar less than 150. A review of physician orders, dated 10/3/25, indicated 8 units of the insulin Lispro was to be given three times a day. If the blood glucose was less than 150, the insulin dose was not to be given.A review of physician orders, dated 10/13/25, indicated 42 units of Lantus insulin were to be given to Resident B every evening at bedtime.A review of the MAR dated, 10/1/25-10/31/25, indicated Resident B was given 8 units of insulin on 10/9/25 at 6:00 PM for a blood sugar of 102, 10/12/25 at 6 pm for a blood sugar of 147, 10/18/25 at 6:00 PM for a blood sugar of 134, 10/25/25 at 6:00 PM for a blood sugar of 119. No documentation of insulin administration was found on 10/15/25 at 6:00 PM for a blood glucose measuring 221 or on 10/20/25 at 6:00 PM for a blood glucose measuring 167. On 10/30/25, a blood glucose of 159 was recorded at 8:00 AM, the site of administration was documented with the letter N. 42 units of Lantus was not documented as given on 10/27/25.A review of the MAR notes on 10/30/25 indicated there were no notes the resident received the insulin dose or if they did not. N is not a documented abbreviation for a subcutaneous insulin injection site.A review of progress notes, dated 9/1/25 to 11/1/25, indicated no explanations or documentation regarding the missing insulin doses, or documentation for giving the insulin without an order from the physician.2. A record review for Resident C, began on 11/18/25 at 1:30 PM. Diagnoses included type 2 diabetes with diabetic polyneuropathy, peripheral vascular disease, congestive heart failure, atherosclerotic heart disease, and chronic kidney disease.A review of physician orders, dated 6/9/25-9/11/25, indicated blood glucose was to be measured three times a day.A review of physician orders, dated 6/9/25-9/11/25, indicated 3 units of insulin Lispro was to be administered if blood glucose was above 200.A review of physician orders, dated 6/10/25-9/8/25, indicated 42 units of Lantus was to be given every evening, at bedtime.A review of physician orders, dated 8/18/25-8/25/25, indicated 7.5-325 mg of hydrocodone-acetaminophen was to be given to Resident C four times a day.A review of physician orders, dated 8/25/25-9/11/25, indicated 7.5-325 mg of hydrocodone-acetaminophen was to be given to Resident C four times a day.A review of the MAR, dated 8/1/25-8/31/25, indicated Lantus insulin was not documented as given or refused on 8/1/25 and 8/10/25. Blood glucose was not recorded on 8/31/25 at 6 pm. No documentation of Lispro (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administration was found on 8/1/25 at 6:00 PM for a glucose of 272, 8/4/25 at noon for a glucose of 255. No administration or refusal of Lispro was indicated on 8/31/25. 42 units of Lantus were given between 7:00 PM and 10:00 PM without a recorded blood glucose measurement. No documentation of hydrocodone-acetaminophen administration or refusal was indicated on 8/21/25 at 12:00 AM. 3. A record review for Resident D began on 11/19/25 at 9:35 AM. Diagnoses included type 2 diabetes with diabetic peripheral angiopathy with gangrene and chronic kidney disease, right leg below the knee amputation. Resident D routinely leaves the facility for dialysis on Mondays, Wednesdays, and Fridays.A review of Resident D's current quarterly MDS, dated [DATE], indicated their BIMS (Basic Interview for Mental Status) score was 14. (cognitively intact). The MDS indicated the resident received insulin injections 5 days a week during the previous week of the assessment.A review of physician orders, dated 9/18/25-10/20/25, indicated blood glucose was to be measured four times a day.A review of physician orders, dated 9/18/25-10/6/25, indicated 18 units of insulin glargine was to be given once a day. The order did not provide parameters to hold insulin or to hold on dialysis appointments.A review of physician orders, dated 10/6/25, indicated 18 units of Rezvoglar Kwik Pen insulin glargine was to be given once a day. The order did not provide parameters to hold insulin or to hold on dialysis appointments.A review of the MAR, dated 10/1/25-10/31/25, indicated blood glucose was not documented as completed or refused on Sunday 8/5/25 at 8:00 AM, Tuesday 10/7/25 at 5:00 PM, and Tuesday 10/14/25 at 8:00 AM. The 8:00 AM of 18 units of insulin glargine was held by facility staff, without physician parameters, on 10/6/25 for glucose of 120, 10/10/25 for a glucose of 93, 10/12/25 for a glucose of 132, 10/13/25 for a glucose of 121, 10/14/25 a note indicated the glucose was not measured prior to Resident D leaving the facility for a procedure, 10/22/25 a note indicated the resident was going to dialysis, 10/23/25 for a glucose of 124, 10/26/25 for a glucose of 100, 10/28/25 for a glucose of 95, and 10/30/25 for a glucose of 108. The MAR indicated, 18 units Resvoglar insulin was routinely not given to Resident D on Mondays, Wednesdays, and Fridays (dialysis days), except for Monday 10/27/25 prior to dialysis. In an interview, on 11/19/25 at 3:02 PM, LPN 4 indicated staff routinely obtained a blood sugar measurement within an hour before meals and bedtime. When insulin was required, within the parameters ordered, a Qualified Medical Assistant would need to have a nurse administer the insulin dose. Documentation was required on the MAR. When a resident was not in the building, staff would document the resident was not available or LOA.A current procedure, dated 2/2010, provided by the Administrator, indicated medications held or refused will be documented in the MAR. Medication administration will be documented on the MAR after the medication has been given. Insulin type, units to be given should be checked against the physician order at least 3 times for accuracy prior to administration.A current policy, dated 2/2003, provided by the Administrator, indicated staff was to administer medications and meals before or after dialysis as ordered.This citation is related to intake 2649663 and 2626035.3.1-30(a)