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	09/19/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review, the facility failed to ensure protective smoking equipment was provided and a electronic cigarette vapor free indoor room environment was provided for 2 of 20 residents reviewed (Resident 40 and Resident 17).Findings included:1) During an observation, on 09/15/2025 at 9:39 AM, Resident 40 was in the smoking area outdoors smoking a cigarette and was not wearing a smoking apron. During an observation, on 09/16/2025 at 1:32 PM, the Assistant Culinary Manager (ACM) lit a cigarette for Resident 40 in the outdoor smoking area. Resident 40 was not wearing a smoking apron. The ACM, approached Resident 36, assisted him in putting on a smoking apron and lit Resident 36's cigarette. The ACM continued giving out and lighting cigarettes for several other residents in the smoking area with his back turned to Resident 40. During an observation, on 09/16/2025 at 1:34 PM, the Administrator entered the smoking area and asked another staff member to get an apron for Resident 40. Resident 40 indicated to the Administrator he was not going to wear the apron. No additional conversation regarding encouragement or risks occurred. The Administrator returned to the building. Resident 40 requested an additional cigarette from the ACM. The ACM gave him another cigarette, lit it and observed Resident 40 until he finished the cigarette, disposed of the cigarette and assisted Resident 40 back to the building. Resident 40's record was reviewed on 09/16/2025 at 1:36 PM. Diagnoses included vascular dementia with behavioral disturbance, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side, diabetes mellitus due to underlying condition with diabetic neuropathy and nicotine dependance. A review of Resident 40's current annual Minimum Data Set (MDS) assessment, dated 8/7/2025, indicated his Basic Interview for Mental Status (BIMS) score was 13 (cognitively intact). A current smoking assessment, dated 8/7/2025, indicated Resident 40 had been observed having careless smoking with a potential to drop his cigarette. The assessment indicated the resident should have a smoking apron. A document listing smoking times and names of persons who smoked, provided by the Administrator on 09/15/2025 at 11:12 AM, indicated Resident 40 should use a smoking apron while smoking. A current care plan, revised 08/16/25, titled Resident currently uses tobacco, indicated Resident 40 smoked cigarettes with a potential for non-compliance, with a goal date of 11/16/2025. The care plan indicated Resident 40 should be provided with a smoking apron and supervised while smoking. The care plan indicated the smoking policy should be explained to Resident 40 with reminders as needed. During an interview, on 09/16/2025 at 2:33 PM, the ACM indicated he told the Activity Director Resident 40 refused his apron while inside the building, prior to going out to the smoking area. He indicated he lit Resident 40's cigarette prior to the Administrator arriving in the smoking area to talk to Resident 40. During an interview, on 09/16/2025 at 2:39 PM, the Administrator indicated the smoking policy did not address what staff should do when a resident refused his smoking apron. She indicated the staff member should not have lit the cigarette until the Administrator addressed the refusal. A current policy titled Smoking Policy, dated 09/2024, provided by the Administrator on 09/16/2025 at 01:15 PM indicated a smoking assessment must be completed upon admission, quarterly and with a significant change for all residents wishing to smoke. The policy indicated the smoking assessment determined the amount of safety equipment required for each (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident. Safety equipment requirements should be care planned and communicated to staff monitoring smoking. The policy indicated residents found to be non-compliant with the policy should have an immediate meeting with facility staff to discuss all options for safety reasons. 2) During an interview, on 09/16/2025 at 10:36 AM, Resident 13 indicated she was allowed to maintain her vaping supplies herself in her room She indicated she was allowed to vape in her room or outside in the smoking area during her assigned smoking times. She indicated her roommate was present in the room when she vaped Resident 13 indicated she shared a room with Resident 17 and Resident 17 did not care if she vaped in the room. During an observation, on 09/16/2025 at 1:43 PM, Resident 13 was observed removing a vape cartridge from her handbag and using it in the facility smoking area outdoors. Resident 13's record was reviewed on 9/16/2025 10:36 AM. Diagnoses included anxiety disorder and nicotine dependence. A review of Resident 13's current quarterly Minimum Data Set (MDS) assessment, dated 8/20/25, indicated she had a Basic Interview for Mental Status (BIMS) score of 15 (cognitively intact). A current care plan, dated 8/25/2025, indicated Resident 13 had a problem of use of an electronic cigarette with a goal date of 11/24/2025. The care plan had a goal of maintaining safety with an approach of reviewing the electronic cigarette policy upon admission and as needed. 3) Resident 17's record was reviewed on 09/19/25 9:48 AM. Diagnoses included anxiety disorder, Bipolar disorder, and psychotic disorder. A review of Resident 17's current quarterly Minimum Data Set (MDS) assessment, dated 8/12/25, indicated she had a Basic Interview for Mental Status (BIMS) score of 7 (cognitively impaired) The MDS indicated Resident 17 displayed disorganized thinking and difficulty focusing in conversation. During an interview, on 09/19/2025 at 9:57 AM, the Director of Nursing indicated Resident 17, a cognitively impaired resident with difficulty focusing and disorganized thinking was unable to give consent to another resident vaping in their room She indicated smoking status did not imply consent to vape in the room. During an interview, on 09/19/2025 at 12:16 PM, the Administrator indicated the facility followed the city ordinance exceptions in regard to indoor electronic cigarette use. A City ordinance, dated indicated private or semi private rooms, in Nursing Homes where resident both smoked and had requested to be placed in a room where smoking was permitted were allowed electronic vaping provided the vapor did not infiltrate into other areas of the facility. A current policy, titled Electronic Cigarettes, dated 7/2017, provided by the Administrator on 09/16/2025 1:15 PM, indicted the IDT team should meet to determine if a resident is appropriate for use of an electronic cigarette based on cognitive ability and eye hand coordination. Prior to the use of the electronic cigarette, the resident's roommate should be consulted as to comfort with the use of the electronic cigarette in their room.3.1-45(a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure respiratory care was consistent with professional standards of practice for 1 of 3 residents reviewed. (Resident 42)During a continuous observation on 9/18/2025 from 2:33 PM to 2:52 PM, Certified Nursing Assistant (CNA) 6 replaced the water container for Resident 42's oxygen humidity. Water in the container entered the nasal cannula tubing. When CNA 6 connected the water container to the oxygen, the water rose up the nasal cannula to the resident's nose and dripped large water droplets. CNA 6 removed the nasal cannula from Resident 42, placed the tubing in the bag attached to the oxygen concentrator, and turned off the oxygen flow. CNA 6 verbalized the intention to notify the nurse and left the room. At 2:51 PM, LPN 7 entered Resident 42's room. Resident 42's oxygen saturation measured 88% on room air. A new nasal cannula was applied and oxygen flow was started by LPN 7 at 2:52 PM. In an interview, on 09/18/2025 at 2:55 PM, LPN 7 indicated that CNAs are allowed to change the oxygen water humidifier. LPN 7 indicated she was told Resident 42 was out of water, not that the resident was without oxygen. A record review for Resident 42's began on 9/18/2025 9:28 AM. Diagnoses included chronic obstructive pulmonary disease (COPD), asthma, anemia, heart failure, and Alzheimer's.A review of Resident 42's current quarterly MDS, dated [DATE], indicated their BIMS (Basic Interview for Mental Status) score was 6 (severe cognitive impairment). The MDS indicated the resident required oxygen therapy for chronic respiratory failure with hypoxia (low oxygen saturation).A review of physician orders, dated 5/29/25, indicated oxygen delivery should be at 3 liters per minute (lpm). A review of physician orders, dated 9/19/25, indicated oxygen delivery should be at 2 liters per minute, but may increase to 4 lpm to keep oxygen saturation above 90%.A current undated policy, provided by the Director of Nursing on 9/19/2025 at 8:56 AM, indicated the water humidifier was to be attached, the oxygen flow adjusted, then attach the oxygen tubing to the port and fit the nasal cannula to the resident.A review of the Indiana State Department of Health, Nurse Aide Curriculum dated 9/19/2015 indicated nursing assistants never stop, adjust, or initiate the use of oxygen.A review of the CNA Procedure titled Nasal Cannula Care, provided by the Regional Nurse Administrator, on 9/19/25 at 12:56 PM, indicated the nursing assistant could remove the nasal cannula, clean the skin around the nose, and reapply the nasal cannula before removing gloves, and leaving the room.The procedure did not indicate the CNA could remove or turn off the oxygen3.1-47(a)(6)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure behavior was identified, tracked and interventions initiated for 1 of 3 residents reviewed. Findings include:On 9/15/25 at 1:45 PM, Resident 63 was observed in the hallway sitting in their wheelchair. Resident 63's face and head were covered with scarves, only their eyes were visible. Resident 63 was holding 2 foam toy guns. Resident 63 fired a foam bullet, striking a passerby with a foam bullet. Resident 63 then propelled their wheelchair away quickly.On 9/16/25 at 2:40 PM, Resident 63 was observed in their wheelchair in the hallway. Resident 63 was holding 2 foam toy guns. Resident 63 stood briefly and pointed their toy guns at a passerby. 2 staff members were present in the hallway but did not intervene.In an interview, on 9/16/25 at 9:30 AM, Resident 5 indicated some residents were afraid of Resident 63. Resident 5 indicated Resident 63 did whatever they want, and the staff would not intervene.In an interview, on 9/16/25 at 9:31 AM, Resident 13 indicated Resident 63 vaped and screamed in the hallways. Resident 13 indicated Resident 63 blared loud music. Resident 13 indicated the staff would not intervene. Resident 13 indicated Resident 63 had an active arrest warrant.In an interview, on 9/18/25 at 10:42 AM, the Administrator indicated they had asked Resident 63 to put away their foam guns on the day the resident was admitted . The Administrator indicated they had asked the resident not to vape in the hallways, and the resident had complied. The Administrator indicated Resident 63 had not been observed pointing their foam guns at other residents. The Administrator indicated they were aware of one resident having reported Resident 63 blaring loud music at 4 in the morning.1.Resident 5's record was reviewed on 9/18/25 at 9:50 AM. Resident 5's admission Minimum Data Set, (MDS) dated [DATE], indicated Resident 5's Brief Interview for Mental Status (BIMS) score was 15 (no cognitive loss).2.Resident 13's record was reviewed on 9/18/25 at 10:10 AM. Resident 13's Quarterly Minimum Data Set, (MDS) dated [DATE], indicated Resident 13's Brief Interview for Mental Status (BIMS) score was 15 (no cognitive loss).3.Resident 63's record was reviewed on 9/15/25 at 2:30 PM. Diagnoses included anxiety, insomnia, pain disorder, post traumatic stress disorder (PTSD) and schizophrenia.Resident 63's care plan, dated 9/5/25, indicated Resident 63 had chosen to smoke.Resident 63's care plan, dated 9/8/25, indicated Resident 63 had a history of substance use disorder.Resident 63's care plan, dated 9/8/25, indicated Resident 63 was at risk for anxiety.Resident 63's care plan, dated 9/9/25, indicated the resident had PTSD due to poor family support, childhood abuse and had survived being shot during an attempted murder. The care plan indicated the resident had received special education services while in school. The care plan indicated Resident 63 had been incarcerated.Resident 63's care plan did not indicate they had disruptive behaviors of screaming, blaring loud music or vaping in the hallways.Resident 63's care plan did not indicate they had attempted to shoot people with foam guns.Resident 63's care plan summary for direct care staff (profile) indicated the resident had diagnoses of schizophrenia, anxiety, epilepsy, insomnia and a history of noncompliance.Resident 63's profile did not indicate the resident had disruptive behaviors of screaming and playing loud music. The profile did not indicate Resident 63 had foam guns in the hallways. The profile did not indicate any interventions to address Resident 63's behavior.Resident 63's Medication Administration Record (MAR), dated August 2025, did not include any tracking or interventions related to Resident 63's behaviors. In an interview, on 9/18/25 at 12:18 PM, the Social Services Director indicated she had nothing to add. She indicated there was no identification and no tracking unless it was on the MAR.A current facility policy, dated 10/2022, indicated staff would be educated in regard to resident specific interventions for behavioral issues.3.1-43(a)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure monitoring of refrigerated medications in accordance with manufacturer guidelines in 1 of 1 refrigerated storage units reviewed. (Resident 4, Resident 50 and Resident 23)During an observation on 9/19/25 at 11:00 AM, the medication storage room had a freezer and refrigerator log missing internal temperature measurements for 9/17/25, 9/18/25, and 9/19/25. On 9/16/25, the refrigerator temperature was last recorded as 37 degrees Fahrenheit (F). Inside the refrigerator, the thermometer measured 20 degrees F and felt cold. Licensed Practical Nurse (LPN) 8 observed the thermometer and confirmed it was 20 degrees. A basket of medication pens was found on the second shelf. The medications included Lantus, Ozempic, Rezvoglar, Tresiba, and a vial of Aplisol tuberculin.In an interview, on 9/19/25 at 11:27 AM, LPN 8 indicated refrigerator temperatures are recorded at the end of the day shift, between 2:15 PM- 3:00 PM. LPN 8 indicated the thermometer should be exchanged. LPN 8 notified the Director of Nursing, (DON) the refrigerator were temperatures out of range.A review of the medications in the refrigerator included, 1 Ozempic pen and 4 Degludec insulin pens for Resident 4, 1 Rezvoglar pen for Resident 50, 1 Lispro insulin pen for Resident 23, and a vial of Aplisol tuberculin labeled House Stock. A review of Novo Nordisk manufacturer instructions indicated Degludec and Ozempic should be refrigerated between 36 F to 46 F. The instructions indicated to not use if Ozempic had been frozen. The manufacturer did not include the freezing temperature of Ozempic.A review of [NAME] Lilly manufacturer instructions indicated Rezvoglar and Lispro should be refrigerated between 36 to 46 F until opened. There were no further instructions regarding use. A review of Par Sterile Products manufacturer instructions indicated Aplisol should be refrigerated between 36 to 46 F. There were no further instructions regarding use. In an observation, on 9/19/2025 at 11:36 AM, a different thermometer indicated the internal refrigerator temperature was 40 degrees F. A current policy, dated 11/2024, provided by the DON, indicated medications would be stored in the refrigerator between 36-46 degrees F. The policy indicated the facility should monitor the refrigerator at least once daily.3.1-25(m)