

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155159	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/26/2015
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NAME OF PROVIDER OR SUPPLIER SUMMIT CITY NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 2940 N CLINTON ST FORT WAYNE, IN 46805
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey date: January 20, 21, 22, 23, and 26, 2015</p> <p>Facility number: 000079 Provider number: 155159 AIM number: 100266160</p> <p>Survey Team: Tim Long, RN-TC Rick Blain, RN Diane Nilson, RN Carol Miller, RN (1/20, 22, 23, 26, 2015)</p> <p>Census bed type: SNF/NF: 80 Total: 80</p> <p>Care Payor type: Medicare: 8 Medicaid: 64 Other: 8 Total: 80</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by Debora Barth, RN.</p>	F000000	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a post survey review on or after February 25, 2015. We respectfully request a desk review in lieu of a post survey revisit.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is</p>			

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	<p>verified appropriate corrective action must be taken.</p> <p>Based on record review and interviews, the facility failed to ensure an allegation of abuse was reported to the Indiana State Department of Health. This affected 1 of 2 residents reviewed for allegations of abuse, Resident #18.</p> <p>Findings include:</p> <p>A family member was interviewed, on 1/20/15, at 3:48 P.M., and indicated Resident #18 had reported to him an incident of sexual abuse. He indicated he had reported this to the Administrator.</p> <p>The record for Resident #18 was reviewed, on 1/22/15 at 10:12 A.M.</p> <p>A Social service progress note, dated 12/15/14, indicated an initial Minimal Data Set (MDS) assessment indicated the resident was severely cognitively impaired.</p> <p>The Social Service Director was interviewed, on 1/23/15 at 8:25 A.M., and indicated she did a follow-up report to the allegation. She indicated the allegation occurred on the weekend, and the Director of Nursing Services (DNS) was notified as well as the Administrator. She indicated a meeting was held on</p>	F000225	<p>F225</p> <p>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>It is the policy of this facility to report all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <ul style="list-style-type: none"> Reportable submitted to Indiana State Department of Health on 2-4-15. <p>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;</p> <ul style="list-style-type: none"> All residents had the potential to have been affected by the alleged deficient practice. All staff will be in-serviced on the facility abuse policy. Education will be provided by the Director of Nursing/Designee and completed by February 25, 2015. <p>what measures will be put into place or what systemic changes will be made to ensure that</p>	02/25/2015

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	<p>12/15/14, with the Administrator, DNS, and the resident's family member. She indicated after this meeting, the Social Service Director (SSD) met with the resident, however, she indicated the resident was always confused. She indicated neither the resident or the family member could identify who abused the resident or when the resident was allegedly abused.</p> <p>Two (2) documents regarding an allegation of abuse for Resident #18, and the Abuse policy were laying on the table in the Social Service office, on 1/22/15, 2:45 P.M. The documents which were an investigation of the allegation of abuse and the abuse policy were reviewed, on 1/22/15, at 3:00 P.M.</p> <p>The first document, dated 12/14/14, and signed (but illegible), indicated an allegation of sexual abuse had been made by the family member of Resident #18. An investigation was started. The resident, all staff members working on the unit, and residents on the unit were interviewed. None of the staff or residents, including Resident #18, indicated any abuse had occurred.</p> <p>The second document, dated 12/15/14, was not signed, but indicated accusations of sexual abuse had been made on</p>		<p>the deficient practice does not recur;</p> <ul style="list-style-type: none"> · New Executive Director began on January 26, 2015 and will be in-serviced by the Corporate Compliance Officer from Home Office. · When an abuse allegation is reported to the Administrator, the Administrator will report to Indiana State Department of Health immediately. · All Abuse allegations will be discussed during IDT to ensure Abuse Policy is followed. · All staff will be in-serviced on the facility abuse policy. Education will be provided by the Director of Nursing/Designee and completed by February 25, 2015. <p>how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and</p> <ul style="list-style-type: none"> · A CQI monitoring tool called Abuse Reporting Audit Sheet will be utilized every week x 4, Monthly x 5 for at least 6 months. · Data will be collected by DNS/Designee and submitted to the CQI Committee. If the threshold of 95% is not met, an action plan will be developed. · Non-Compliance with facility procedure may result in disciplinary action up to and including termination. 		

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	<p>12/14/14, and a meeting was held with the DNS, Administrator, SSD, and family member of Resident #18 on 12/15/14. The document indicated the SSD also met with the resident, who was confused, but denied any mistreatment or sexual misconduct by any means.</p> <p>The Abuse Prohibition, Reporting, and Investigation policy indicated the following: "The Executive Director/designee will report all unusual occurrences, which include allegations of abuse, immediately, to the Long Term Care Division of the Indiana State Department of Health."</p> <p>The Administrator was interviewed, on 1/23/15, at 8:20 A.M., and indicated the allegation of sexual abuse had not been reported to the ISDH.</p> <p>The Director of Nursing Services (DNS) was interviewed, on 1/23/15, at 1:50 P.M., and indicated she wrote up the investigation, dated 12/14/14.</p> <p>The SSD was interviewed, on 1/26/15, at 12:15 P.M., and indicated she had documented the investigation, dated 12/15/14, but neglected to sign it.</p> <p>3.1-28(a)</p>		<p>by what date the systemic changes will be completed. February 25, 2015</p>				

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F000226 SS=D	<p>3.1-28(c) 3.1-28(e)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interviews, the facility failed to ensure their abuse prohibition policy was followed concerning an allegation of abuse being reported to the Indiana State Department of Health. This affected 1 of 2 residents reviewed for abuse, Resident #18.</p> <p>Findings include:</p> <p>A family member was interviewed, on 1/20/15, at 3:48 P.M., and indicated Resident #18 had reported to him an incident of sexual abuse. He indicated he had reported this to the Administrator.</p> <p>The record for Resident #18 was reviewed, on 1/22/15 at 10:12 A.M.</p> <p>A Social service progress note, dated 12/15/14, indicated an initial Minimal Data Set (MDS) assessment indicated the resident was severely cognitively impaired.</p>	F000226	<p>F226 DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES It is the policy of this facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - Reportable submitted to Indiana State Department of Health on 2-4-15.</p> <p>howother 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 had the potential to have been affected by the alleged deficient practice. - All staff will be in-serviced on the facility abuse policy.</p>	02/25/2015

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	<p>The Social Service Director was interviewed, on 1/23/15 at 8:25 A.M., and indicated she did a follow-up report to the allegation. She indicated the allegation occurred on the weekend, and the Director of Nursing Services (DNS) was notified as well as the Administrator. She indicated a meeting was held on 12/15/14, with the Administrator, DNS, and the resident's family member. She indicated after this meeting, the Social Service Director (SSD) met with the resident, however, she indicated the resident was always confused. She indicated neither the resident nor the family member could identify who abused the resident or when the resident was allegedly abused.</p> <p>Two (2) documents regarding an allegation of abuse for Resident #18, and the Abuse policy were laying on the table in the Social Service office, on 1/22/15, 2:45 P.M. The documents which were an investigation of the allegation of abuse and the abuse policy were reviewed, on 1/22/15, at 3:00 P.M.</p> <p>The first document, dated 12/14/14, and signed (but illegible), indicated an allegation of sexual abuse had been made by the family member of Resident #18. An investigation was started. The</p>		<p>Education will be provided by the Director of Nursing/Designee and completed by February 25, 2015. what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <ul style="list-style-type: none"> · New Executive Director began on January 26, 2015 and will be in-serviced by the Corporate Compliance Officer from Home Office. · When an abuse allegation is reported to the Administrator, the Administrator will report to Indiana State Department of Health immediately. · All Abuse allegations will be discussed during IDT to ensure Abuse Policy is followed. · All staff will be in-serviced on the facility abuse policy. Education will be provided by the Director of Nursing/Designee and completed by February 25, 2015. <p>how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and</p> <ul style="list-style-type: none"> · A CQI monitoring tool called Abuse Reporting Audit Sheet will be utilized every week x 4, Monthly x 5 for at least 6 months. · Data will be collected by DNS/Designee and submitted to the CQI Committee. If the 	

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	<p>resident, all staff members working on the unit, and residents on the unit were interviewed. None of the staff or residents, including Resident #18 indicated any abuse had occurred.</p> <p>The second document, dated 12/15/14, was not signed, but indicated accusations of sexual abuse had been made on 12/14/14. A meeting was held with the DNS, Administrator, SSD, and family member of Resident #18 on 12/15/14. The document indicated the SSD also met with the resident , who was confused, but denied any mistreatment or sexual misconduct by any means.</p> <p>The Abuse Prohibition, Reporting, and Investigation policy indicated the following: "The Executive Director/designee will report all unusual occurrences, which include allegations of abuse, immediately, to the Long Term Care Division of the Indiana State Department of Health."</p> <p>The Administrator was interviewed, on 1/23/15, at 8:20 A.M., and indicated the allegation of sexual abuse had not been reported to the ISDH.</p> <p>The Director of Nursing Services (DNS) was interviewed, on 1/23/15, at 1:50</p>		<p>threshold of 95% is not met, anaction plan will be developed.</p> <ul style="list-style-type: none"> Non-Compliance with facility proceduremay result in disciplinary action up to and including termination. <p>by what date thesystemic changes will be completed.</p> <ul style="list-style-type: none"> February 25, 2015 	

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F000441 SS=D	<p>P.M., and indicated she wrote up the investigation, dated 12/14/14.</p> <p>The SSD was interviewed, on 1/26/15, at 12:15 P.M., and indicated she had documented the investigation dated 12/15/14, but neglected to sign it.</p> <p>3.1-28(a)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin</p>						

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	<p>lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility failed to ensure 1 of 1 staff observed for Ventilator Care failed to follow infection control procedures for handwashing and glove use during tracheostomy care. This affected 1 of 1 residents observed for Ventilator Use, Resident #18.</p> <p>The facility also failed to ensure a staff member wore a gown in an isolation room while emptying urine from a catheter bag. This affected 1 of 3 residents observed for Urinary Catheter use, Resident #72.</p> <p>Findings include:</p> <p>1. Respiratory Therapist (RT) #1 was observed doing a breathing treatment and tracheostomy care on Resident #18 on 1/22/15 at 1:04 P.M. She indicated the resident was in contact isolation. The resident was observed lying in bed with a</p>	F000441	<p>F441 INFECTION CONTROL, PREVENT SPREAD, LINENS It is the policy of this facility to ensure that the facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; ·Resident #18 and #72 are receiving proper personal care in a manner in which to prevent the spread of infection. ·C.N.A.# 2 and RT# 1 provided skills validation by Clinical Education Coordinator/Designee to ensure appropriate hand washing, wearing</p>	02/25/2015

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	<p>tracheostomy and ventilator.</p> <p>The RT donned white non-sterile exam gloves, completed a lung assessment, started a breathing treatment, then opened a packet used for tracheostomy care, removed sterile green gloves, and placed the sterile green gloves over the white exam gloves, then proceeded to clean around the tracheostomy site, apply a dressing around the site, and suction the resident's mouth. She then removed the gloves and gown she was wearing, placed the gown, gloves, and what she had used for the tracheostomy care in a clear plastic bag, then without washing her hands, left the resident's room. She proceeded down the hall, through the closed sliding glass door, off the vent unit, to the soiled utility room on the long term care unit. She opened the door and placed the plastic bag in the barrel in the soiled utility room, then walked back down the hall to the vent unit and washed her hands in the dining room sink located on the vent unit.</p> <p>2. CNA # 2 was observed emptying urine out of the foley catheter bag for Resident #72 on 1/22/15, at 1:40 P.M. She indicated the resident was in contact isolation due to an urinary infection. She washed her hands, placed gloves on, and placed the container to empty the</p>		<p>of gowns and proper glove usage.</p> <p>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;</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the alleged deficient practice. · The Infection Control Nurse and Respiratory Therapy Manager will receive one-on-one training from the Home Office Infection Control Consultant/Designee on American Senior Communities' Transmission-based Precaution Guidelines completed by February 25, 2015. · All staff will be in-serviced on the facility Transmission-Based Precaution Guidelines. Education will be provided by the Director of Nursing/Designee and completed by February 25, 2015. <p>what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <ul style="list-style-type: none"> - The Infection Control Nurse and Respiratory Therapy Manager will receive one-on-one training from the Home Office Infection Control Consultant/Designee on American Senior Communities' Transmission-based Precaution 	

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	<p>contents of the urinary catheter bag on a paper towel on the floor. She then proceeded to empty the contents of the bag into the container. She then emptied the urine in the container into the toilet, rinsed the container using water from the sink then emptied this into the toilet. She then removed her gloves and washed her hands.</p> <p>When questioned if she normally wore a gown with this resident due to the contact isolation, she indicated "yes", but she forgot to put the gown on this time.</p> <p>Policies for Transmission-Based Precaution Guidelines, and Tracheostomy Care were laying on the table in the Social Service office on 1/22/15 at 3:00 P.M.</p> <p>Review of the policy for Transmission-Based Precaution Guidelines, on 1/23/15, at 9:00 A.M., and updated most recently in April, 2014, indicated the following: "...Perform hand hygiene as follows: Before having direct contact with a resident; After contact with blood, body fluids or excretions, mucous membranes, non-intact or wound dressing; After contact with intact skin; If hands would be moving from a</p>		<p>Guidelines completed by February 25, 2015.</p> <ul style="list-style-type: none"> All staff will be in-serviced on the facility Transmission-Based Precaution Guidelines. Education will be provided by the Director of Nursing/Designee and completed by February 25, 2015. Skills Validations will be conducted with all RTs on the Ventilator Unit regarding trachcare and handing washing procedures by the CEC by February 25, 2015. Skills Validations will be conducted with all CNAs on the Ventilator Unit regarding Catheter Care procedures by the CEC by February 25, 2015. Director of Nursing/Designee will conduct rounds daily on the Ventilator Unit to ensure appropriate hand washing, wearing of gowns and proper glove usage. 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155159	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/26/2015
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	<p>contaminated-body site to a clean body site during care; After contact with objects or equipment in the residents environment; After removing gloves...."</p> <p>Under the Contact Precaution section of the policy indicated Personal Protective Equipment-Gown was to be placed on upon entry to room/cubicle, and the gown protected clothing from potential contamination from direct contact with the resident, environmental surfaces, or equipment.</p> <p>The policy for Tracheostomy Care(undated) indicated equipment was to be assembled including, but not limited to: "...Tracheostomy Care kit sterile gloves Tracheostomy dressing." The policy indicated, "wash hands for at least 20 seconds with an antimicrobial soap: Don gloves."</p> <p>The Infection Control nurse was interviewed on 1/23/15, at 2:25 P.M. She indicated staff should wash their hands before and after any resident care in the resident's room. She indicated the sink in the dining area on the vent unit was meant to be used for staff to wash their</p>		<p>how the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place; and ·A CQI monitoring tool called Infection Control CQIwill be utilized every week x 4, Monthly x 3, and every other month x3 forat least 3 months. ·Data will be collected by DNS/Designee andsubmitted to the CQI Committee. If the threshold of 95% is not met, anaction plan will be developed. ·Non-Compliance with facility procedure may resultin disciplinary action up to and including termination.</p> <p>by what date thesystemic changes will be completed. February25, 2015</p>	

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	<p>hands when assisting residents in the dining room.</p> <p>The Infection Control nurse was interviewed on 1/26/15. She indicated when a resident was on contact isolation, gowns were placed in cabinets in the resident's room and staff were required to wear gowns and gloves for personal care and exposure to any body fluids.</p> <p>3.1-18(a)</p>				