

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

PRINTED: 02/24/2025

FORM APPROVED

OMB NO. 0938-039

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 11/15/2024	
NAME OF PROVIDER OR SUPPLIER SUMMIT CITY NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP COD 2940 N CLINTON ST FORT WAYNE, IN 46805			
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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: November 12, 13, 14, and 15, 2024. Facility number: 000079 Provider number: 155159 AIM number: 100266160 Census Bed Type: SNF/NF: 49 Total: 49 Census Payor Type: Medicare: 2 Medicaid: 42 Other: 5 Total: 49 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 17, 2024.			F 0000			
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on observation, interview, and record review the facility failed to ensure dignity was provided for 1 of 13 residents reviewed. (Resident 22). Findings include: An observation starting on 11/12/24 at 9:18AM, in the 200 hallway, consisting of rooms 215-228, staff from several departments were observed entering			F 0550	<u>F550 SS=D – Resident Rights</u> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. All staff in facility will be In-service		11/25/2024

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 other safeguards 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 disclosable 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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	<p>resident rooms without waiting for permission or an answer after knocking softly or not knocking at all. Some of the staff did announce what department they were from, none announced their name. Certified Nursing Assistant 4 (CNA) went directly into room 215 without knocking and announced after entering, "who turned the light on?". CNA 5 entered room 228 after tapping with one finger on the door and immediately entering the room. No announcement was made prior to entering. No pause was given between finger tap and entering room. In room 220, several staff were coming and going from the room. There was no knocking or asking permission to enter the resident(s) room. The Activity director, a member of laundry/housekeeping (6), and a CNA (7) were all seen entering without knocking or asking for permission to enter. One of the three did say "hello" upon entering.</p> <p>During an observation, on 11/12/24 at 10:56AM, in Resident 22's room, CNA 7, RN 3, and a member of housekeeping (8) all entered the room without knocking, clarify they did not ask for permission without asking for permission to enter, or announcing themselves by name. The CNA did state "nursing" upon entering the room. Each time someone entered Resident 22 stopped talking mid-sentence.</p> <p>In an interview on 11/12/24 at 10:57 AM, Resident 22 indicated she was embarrassed by the crusty yellow, brown and white patches on her scalp and loss of hair. Resident 22 also complained of being in a gown at near noon and expressed she did own clothing. Resident 22 indicated she did not want her husband to see her in this condition.</p> <p>Resident 22's record review began on 11/12/24 at 2:45PM. Resident 22 diagnoses included</p>				<p>on knocking appropriately, identifying their name and department before entering resident's room.</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> <p>All residents have the risk of not having their rights to Resident Rights.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>Monthly Inservice for the next 12 months will be implemented, IDT members will continue to round the facility daily and educate staff on resident rights and appropriate steps to complete before entering a res room.</p> <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 by what date the systemic changes for each deficiency will be completed.</p> <p>ED/Designee will audit 5 staff</p>		

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F 0697 SS=D	<p>schizoaffective disorder, muscle weakness, major depression, and lack of coordination. Resident 22 did not have any documented diagnosis of skin conditions for her scalp or any physician orders for treatments for scalp.</p> <p>Resident 22's most recent comprehensive, Minimum Data Set (MDS), assessment dated 10/22/24 indicated the following: Section C: Cognitive Patterns. A Brief Interview of Mental Status (BIMS) score of 10, indicated moderate impairment. Section D: Mood Resident mood interview (PHQ-2 9) indicated moderate depression. Section E: Behaviors were scored as none.</p> <p>In an interview, on 11/13/24 at 8:01 AM, Registered Nurse 3 (RN) indicated the proper procedure to entering a resident room was to knock on door wait for an answer and announce yourself. RN 3 confirmed staff were to ask or wait for permission to enter residents' rooms.</p> <p>In an interview, on 11/14/24 at 10:45 AM, the Administrator asked if staff were just knocking and announcing themselves.</p> <p>The Administrator provided an indated policy and procedure for Abuse and Neglect. The policy did not cover resident rights to dignity. The administrator indicated he would look for a check-off in their orientation or other policies to cover entering resident rooms.</p> <p>No policy was made available at the time of exit.</p> <p>3.1-3(p)(1)(t)</p> <p>483.25(k) Pain Management</p>				<p>members every day x5 days a week for the first 2 weeks to ensure compliance. Audits will then be complete x 5 staff x2 weekly for an additional 2 weeks. Monthly audits will then follow of at least 5 staff members every month and followed up with in QAPI.</p> <p>Date of Compliance 11-25-2024</p>		

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Bldg. 00	<p>Based on observation, interview, and record review the facility failed to ensure pain was managed for 1 of 1 resident reviewed. (Resident 22)</p> <p>Findings include:</p> <p>In an interview, on 11/12/24 at 10:12 AM, Resident 22 indicated she was frequently experiencing back pain and not getting any relief from it. Resident 22 indicated she told the nurses and was at times given Tylenol and at other times given reasons she had to wait. Resident 22 indicated the nursing facility staff were aware of her pain. Resident 22 indicated she was rarely given medication for the pain and was not offered any non-pharmaceutical relief. Resident 22 indicated Tylenol was better than nothing but did not relieve the pain.</p> <p>During a continuous observation in Resident 22's room, on 11/12/24 between 10:12 AM and 11:03AM, Resident 22's brows were observed to be crunched, face was grimaced, and there was reddening on her forehead between her eyes. Resident 22 became tearful at times and stopped to catch her breath at other times. Registered Nurse (RN 3) came in to address Resident 22's roommate, at 10:32 AM. Resident 22 stopped her and expressed a great deal of pain. RN 3 did an assessment. Asking for her pain level. Resident 22 indicated her pain level was a 10. RN 3 asked how she was talking if her pain was a 10. Resident 22 indicated her pain was the worst pain she had ever felt, and she was having pain quite frequently as they were all aware. RN 3 asked Resident 22 to describe the pain and the location of the pain. Resident 22 explained slowly the pain was in her back, and it went from a constant throb to at times feeling like she was being stabbed. RN</p>		F 0697	<p><u>F697 SS=D – Pain Management</u></p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p><i>Nursing staff in facility will be In-service on Pain management policy</i></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> <p><i>All residents have the risk of staff not following pain management policy</i></p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>Monthly Inservice and education for the next 12 months will be implemented during all staff in services on pain management and the types of interventions for use per policy.</p> <p>How the corrective action(s) will be monitored to ensure the</p>		11/25/2024	

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	<p>3 indicated she would let Resident 22's nurse know of their discussion and request of pain medication. Resident 22 asked specifically for something more than Tylenol. Resident 22 asked for ibuprofen or tramadol and indicated Tylenol was not effective when the pain was of this level.</p> <p>RN 3 did not ask if there was anything else helpful in relieving the pain, offer turn or reposition, lowering the lights, a message, ice, heat, or soothing music. RN 3 did not offer any other relief.</p> <p>After RN 3 left the room on 11/12/24 about 10:40 AM, Resident 22 went on to explain what happened when she complained of pain. She described someone other than her nurse would come in. She felt talked down to as if she didn't know when she was in pain or not. She indicated much of the time she would not see or talk to the nurse or get any relief from the pain. She indicated she was not offered any pain relief mesures other then medications.</p> <p>Resident 22's record review began on 11/13/24 at 9:21AM. Resident 22's diagnoses included schizoaffective disorder, muscle weakness, diabetes, asthma, swelling, and pain.</p> <p>Resident 22's physician orders related to pain were limited to an order for Tylenol (acetaminophen) 325mg tablet, 650mg every 4 hours as needed. Not to exceed 4grams in 24 hours.</p> <p>Resident 22's most recent comprehensive, Minimum Data Set (MDS), assessment dated 10/22/24 indicated the following: Section C: Cognitive Patterns. A Brief Interview of Mental Status (BIMS) score of 10, indicated</p>				<p>deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed.</p> <p><i>DNS/Designee will audit the facility activity report x5 weekly for 2 weeks, x2 weekly after x 2 weeks, and once a month during QAPI to ensure extra attention is focused on interventions in regard to the Pain Management Policy. Appropriate actions will be taken to give Pharmacological or nonpharmacy logical intervention.</i></p> <p>Date of Compliance</p> <p>11-25-2024</p>		

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	<p>moderate impairment.</p> <p>Section D: Mood Resident mood interview (PHQ-29) indicated moderate depression.</p> <p>Section E: Behaviors were scored as none.</p> <p>Section J: Health Conditions Pain Assessment Interview was not completed.</p> <p>Resident 22's plan of care indicated the problem of at risk for pain related to impaired mobility, diabetes, and asthma, The goal was resident will be free from adverse reactions of pain. The interventions included observing nonverbal signs of pain i.e. changes in breathing, mood/behavior, eyes changing expression, sad/worried face, crying, teeth clenched, and changes in posture. An intervention was to offer non pharmalogical interventions such as a quiet environment, rest, shower, back rub, and reposition.</p> <p>Resident 22's progress notes, printed 11/13/24 at 11:09 AM, indicated the most recent entry of a complaint of back pain was on 11/7/24 and Tylenol was administered. The entry did not have documented non pharmacologic attempts for pain relief. The progress notes dated from 10/16/24 to 11/7/24 had no other documentation of complaints of pain.</p> <p>Resident 22's Medication Administration Record (MAR) dated November 2024 was reviewed through November 13. On 11/7/24 Tylenol 325mg (2) tablets were given at 2:32PM for pain, a pain level of 5, location was not indicated, and effectiveness was marked with an E. On 11/13/24 at 12:27PM Tylenol 325mg (2) tablets were given for pain, level was a 4, and location was the back.</p> <p>Resident 22's pain concern on 11/12/24, nor attempts for pain relief were not documented.</p>						

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	A policy and procedure titled, "Pain Management Policy" dated 01/03 and last revised 7/2024, indicated ...to provide the necessary care and services to attain and maintain the highest practicable physical, mental, and psychosocial wellbeing, including pain management ...interviewable resident pain with be given based on intensity of the pain using the verbal descriptive, numerical scale of 0-10 ...Non interviewable resident- pain medications will be given based upon nursing assessment of the following: non verbal sounds, vocal complaints of pain, facial expressions (grimaces, winces, wrinkled forehead, furrowed brows, clenched teeth), protective body movements or postures ...Physician orders for pain medication will be prescribed based upon the resident's intensity of pain. For example, Tylenol for mild to moderate pain. Vicodin for severe to very severe pain... 3.1-37(a)						