STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155159	A. BUILDING 00 B. WING	12/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT CITY NURSING AND REHABILITATION	2940 N CLINTON ST FORT WAYNE, IN 46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F0000	This survey was for the Investigation of Complaints IN00120966 and IN00120969. This survey resulted in a partially extended survey-Immediate Jeopardy. Complaint IN00120966-Substantiated. Federal/state deficiencies are cited at F309. Complaint IN00120969-Substantiated. Federal/state deficiencies are cited at F309 and F328. Survey dates: December 13, 14, 17, 2012 Facility number: 000079 Provider number: 155159 AIM number: 100266160 Survey team: Ann Armey, RN Census bed type: SNF: 65 Total: 65 Census payor type: Medicare: 5 Medicaid: 57 Other: 3 Total: 65	F0000		

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

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	Sample: 4 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2 in regard to the Investigation of Complaints IN00120966 and IN00120969.			

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F0309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure a resident had the means to summon help, during a period when the call system was not operational and prior to a resident's death. This deficiency affected 1 resident ,who expired on the ventilator unit, when the call system was not operational and who was unable to use the bell provided to other residents. (Resident #B) The Immediate Jeopardy began on 12/7/12, when the call system stopped working. The Director of Operations/Interim Administrator and Acting Director of Nursing were notified of the Immediate Jeopardy on 12/13/12 at 6:00 p.m. and the Immediate Jeopardy was removed on 12/14/12, but non-compliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm. Findings include:	F0309	The creation and submission of this Plan of Correctiondoes not constitute an admission by this provider of any conclusion set forthin the statement of deficiencies, or of any violation of regulation. Thisprovider respectfully requests that the 2567 Plan of Correction be consideredthe Letter of Credible Allegation IDR will be Submitted for this deficiency **F 309 Provide Care/Services for Highest well being** Itis the practice of this provider to ensure that each resident must receive andthe facility must provide the necessary care and services to attain of maintainthe highest practicable physical, mental, and psychosocial well-being, inaccordance with the comprehensive assessment and plan of care	01/09/2013

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	On 12/13/12 at 9:00 a.m., during the entrance conference, the Administrator was interviewed. He indicated, on 12/7/12 at 3:35 a.m., the power company restored power, after a planned power outage and this caused a spike in electricity which damaged electrical systems in the facility, including but not limited to; furnace controls, electric bed motors, computers, and the call light system. The Administrator indicated, the call system stopped working, on 12/7/12 at 3:50 p.m. and 15 minute checks were initiated, bells were passed out to residents, and adult monitors were placed in the ventilator dependent resident rooms. The Administrator indicated the call system was repaired on 12/12/12. Information provided by the Administrator indicated the monitors, with remote auditory capabilities, were purchased on 12/8/12 at 2:27 p.m. and the bells were collected from sister facilities on 12/7/12 at 4:00 p.m. On 12/13/12 at 11:00 a.m., RT (Respiratory Therapist) #16 indicated, during the evening of 12/7/12 , Resident #B's ventilator was removed by a nurse, at the resident's request and his tracheostomy was capped with a passy-muir valve so he could speak. RT #16 indicated he checked Resident #B on 12/8/12 at 1:10 a.m. and Resident #B		**What corrective action(s)will be accomplished for those residents found to have been affected by thedeficient practice** •□□□□□□□□ResidentB no longer resides at the facility **How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken** •□□□□□□□□Residents residing in the facility have thepotential to be affected by the alleged deficient practice •□□□□□□□□In-service will be conducted for staff on thefacility's plan of action regarding call light interruption procedures andreplacement system by the Executive Director or designee by January 9 th , 2013 •□□□□□□□□Call light system was replaced/repaired on12-12-12 **What measures will be putinto place or what systemic changes you will make to ensure that the deficientpractice does not recur** •□□□□□□□□In-service will be conducted for staff on thefacility's plan of action regarding call light interruption procedures	

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	still did not want to be placed on the ventilator. The RT indicated the call system was down and the resident did not have a bell because he couldn't use it. He indicated the nurse checked the resident at 4:45 a.m. and when the Respiratory Therapist checked the resident around 5:00 a.m., the resident was pulseless and unresponsive. The RT indicated he initiated CPR (Cardio Pulmonary Resuscitation) and there was no evidence of airway obstruction when he was ventilating the resident. On 12/13/12 at 11:30 a.m., the Nurse Practitioner was interviewed. She indicated Resident #B had muscular dystrophy, was extremely fragile and was not able to move. She indicated he used a special call pad positioned by his head to summon help. The Nurse Practitioner indicated she did not think the resident could use a call bell to summon help. On 12/13/12 at 11:45 p.m., the Housekeeping Supervisor was interviewed. She indicated she did 15 minute monitoring of residents on the ventilator unit, when the call system was not working. She indicated, on 12/8/12 at 4:45 a.m., she checked on Resident #B and he was sleeping. She further indicated		andreplacement system by the Executive Director or designee by January 9 th , 2013 •□□□□□□□□Facility will maintain manual bells toprovide to residents during interruption or malfunction of call light system •□□□□□□□□Residents who cannot utilize the manual bellswill be assessed by the licensed nursing personnel for use of remote adultmonitoring system •□□□□□□□□Residents who cannot verbalize summoning forhelp or do not meet requirements for adult monitoring system, will be providedwith additional staff member for one: one services until call light system isrestored •□□□□□□□□Residents who require ventilator serviceswill be provided additional staff for one: one services until the call lightsystem is restored •□□□□□□□□All residents who reside within the facilitywill be observed every 15 minutes until the call light system is restored •□□□□□□□□The Executive Director or designee isresponsible to ensure follow up and compliance with the required procedure. **How the corrective action(s)will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place** •□□□□□□□□A “call light interruption tool” will be putinto place weekly x	

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	he did not have a bell because he couldn't move. The clinical record of Resident #B was reviewed on 12/13/12 at 2:00 p.m. and indicated the resident was admitted to the facility for respite care, on 11/23/12, with diagnoses which included but were not limited to, muscular dystrophy, respiratory failure, anxiety and ventilator dependence. The MDS (Minimum Data Set), dated 12/1/12, indicated the resident was totally dependent for bed mobility, transfer, dressing, hygiene, and toileting. Resident #B's cognition was intact and he scored 14 out of 15 on the Brief Interview of Mental Status. Respiratory Therapy notes indicated the following: On 11/23/12 at 11:30 a.m., the resident was admitted for respite care and did not require ventilator support other than at night when he was "worn out." On 11/28/12 at 5:00 a.m., the resident was on a ventilator during the night. "...I would recommend a sitter while here for respite care due to staff being unable to meet residents needs successfully in a timely manner." On 12/7/12 at 2:50 a.m., Resident #B used a passy-muir valve during the day		4 weeks and then quarterly thereafter to assure complianceis met threshold of 100%. •□□□□□□□□The CQI team will review the datacollected. If threshold is not achieved,an action plan will be developed, to ensure compliance **Compliance date:** January9th, 2013	

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	and a ventilator at night. On 12/8/12 at 5:55 a.m., "at 0500 A.M. patient was found unresponsive, pulseless. CPR (Cardiopulmonary Resuscitation) initiated immediately with chest compressions. Tracheotomy cuff filled with sterile saline and Bag-mask ventilation was started c (with) 100% oxygen at 15 LPM (Liters Per Minute) Flow. CPR continued with EMS (Emergency Medical Services) arrival at approx (approximately) 05:15 AM. Patient/resident refused to wear ventilator t/o (through out) the night. Explained to resident the importance of wearing the ventilator at night." On 12/8/12 at 5:32 a.m., Nursing Progress Notes indicated the resident was alert and took a sip of water at approximately 4:45 a.m .and at approximately 5:10 a.m., the respiratory therapist entered the resident's room and found the resident non-responsive and not breathing. The fifteen minute monitoring log indicated the resident was last checked at 5:00 a.m. by CNA #17. On 12/17/12 at 12:15 p.m., CNA #17 was interviewed. She indicated she checked on Resident #B around 5:00 a.m. and the resident was awake. She indicated about 10-15 minutes later she heard the code being called.			

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	The call system was not operating and Resident #B was unable to use the bells provided to other residents. As a result, Resident #B had no means to summon help at the time of his death. The Immediate Jeopardy that began on 12/7/12, was removed on 12/14/12, but non-compliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm, when the facility developed a plan to ensure all residents would be able to summon help during the interruption or malfunction of the call light system. This Federal tag relates to Complaints IN00120966 and IN00120969. 3.1-37(a) 3.1-19(u)(1)			

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F0328 SS=K	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, interview and record review, the facility failed to ensure the emergency generator was operational during a power outage, resulting in low power alarms activating on ventilators and the inability to use suction equipment for residents who required suctioning to maintain an open airway resulting in the potential for serious harm to 7 of 7 ventilator dependent residents residing on the ventilator unit at the time of the power outage. (Residents #B, #C, #D, #E, #F, #G and #H) The Immediate Jeopardy began on 12/7/12, when the generator failed during a planned power outage. The Director of Operations/Interim Administrator and Acting Director of Nursing were notified of the Immediate Jeopardy on 12/13/12 at 6:00 p.m. and the Immediate Jeopardy	F0328	The creation and submission of this Plan of Correctiondoes not constitute an admission by this provider of any conclusion set forthin the statement of deficiencies, or of any violation of regulation. Thisprovider respectfully requests that the 2567 Plan of Correction be consideredthe Letter of Credible Allegation IDR will be submitted for this deficiency **F 328 Treatment/Care for Special needs** Itis the practice of this provider to ensure that each residents receive propertreatment and care for the following special services: Injections, Parental andenternal fluids; colostomy, ureterostomy, or ileostomy care; Tracheotomysuctioning;	01/09/2013

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	was removed on 12/14/12, but non-compliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm. Findings include: On 12/13/12 at 9:00 a.m., the Director of Operations, who had been acting as the Interim Administrator since 12/11/12, was interviewed. The Administrator indicated the facility was given notice the power company would be switching poles on 12/7/12 and the power to the facility would be shut off. The Administrator indicated, before the planned power outage, the generator was tested on full load and was functioning. The Administrator indicated, when the power company turned off the power on 12/7/12 at 12:30 a.m., the generator kicked in but failed at 2:09 a.m. and the facility was without any power until 3:35 a.m.. The Administrator indicated, cell phones were used, portable oxygen was obtained, flash lights/head lights were provided, and the ventilator batteries functioned on the ventilators. The Administrator indicated there were no adverse outcomes for the residents during the outage. The Administrator further indicated a back-up generator was installed on the		Respiratory care; Foot care; and prostheses. **What corrective action(s)will be accomplished for those residents found to have been affected by thedeficient practice** •□□□□□□□□ResidentB no longer resides at the facility •□□□□□□□□ResidentC, D, E, F, G, and H. Facility does maintain suction machines that will operatewith battery back-up in case of power interruption •□□□□□□□□In-servicewill provided to licensed nursing staff and Respiratory Therapy to ensureoperation of the suction machines during power interruption by the Executive Directoror designee by January 9 th , 2013. **How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken** •□□□□□□□□Residents residing in the facility have thepotential to be affected by the alleged deficient practice •□□□□□□□□In-servicewill provided to licensed nursing staff and Respiratory Therapy to ensureoperation of the suction machines during power	

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	morning of 12/7/12 and the facility's generator was scheduled for repairs. The Administrator provided a timeline of events and an inservice training record which indicated, staff were inserviced, after the incident, on 12/7/12 at 5:20 a.m., regarding the disaster plan for power outages and all nurses on duty were in-serviced and checked off for bagging (providing manual ventilation by hand) ventilator residents. On 12/13/12 at 10:30 a.m., during the tour of the ventilator unit, five residents were identified as being ventilator dependent. On 12/13/12 at 11:55 a.m., the suction machines, in the rooms on the ventilator unit and on the second floor crash cart, were checked by the Respiratory Therapist and did not have battery back-up and would not operate without electricity. On 12/13/12 at 12:00 p.m., two suction machines on the first floor were checked. The suction machines would not operate without electricity and did not have a battery back-up. On 12/13/12 at 12:15 p.m., the Administrator indicated two suction machines with battery back-up had been ordered and would arrive in the facility on 12/14/12.		interruption by the ExecutiveDirector or designee by January 9 th , 2013 •□□□□□□□□In-service will be provided to licensednursing personnel and respiratory Therapy in case of a power interruption andthe low battery indicator is alarming for the ventilator machines staff willlocate replacement battery for the ventilator machines and replace currentbattery following procedure for battery replacement. Replacement batteries are located in therespiratory office by the Executive Director or designee. In-service will be completed by January 9 th ,2013. **What measures will be putinto place or what systemic changes you will make to ensure that the deficientpractice does not recur** •□□□□□□□□In-servicewill provided to licensed nursing staff and Respiratory Therapy to ensureoperation of the suction machines during power interruption by the ExecutiveDirector or designee by January 9 th , 2013 •□□□□□□□□Facility will maintain suction machines thatwill operate with battery backup in case of power interruption. •□□□□□□□□In-service will be	

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	Staff working on the ventilator unit, during the electrical outage, were interviewed: On 12/13/12 at 1:45 p.m., CNA (Certified Nursing Assistant) #10 indicated she was assisting on the ventilator unit during the outage and there were six to seven ventilator residents on the unit. She indicated about an hour after the generator failed, the ventilator alarms started sounding, due to low batteries. The RT (Respiratory Therapist) had to switch Resident #C to another ventilator because the battery was low. CNA #10 indicated the RT had CNAs and Nurses stationed in every ventilator room and they were told they would have to bag the residents if the ventilators batteries ran out. The CNA indicated a lot of the staff were scared. The CNA indicated the suctions machines would not work either and staff were using cell phones or flashlights to see in the dark. . On 12/13/12 at 2:00 p.m., CNA #11 indicated she was assisting the Respiratory Therapist after the generator stopped functioning and the electricity went out. She indicated she helped to get oxygen from storage, so portable tanks could be used for residents on the ventilator unit. She indicated after an hour, the ventilators began beeping. CNA #11 indicated there was someone		provided to licensednursing personnel and respiratory Therapy in case of a power interruption andthe low battery indicator is alarming for the ventilator machines staff willlocate replacement battery for the ventilator machines and replace currentbattery following procedure for battery replacement. Replacement batteries are located in therespiratory office by the Executive Director or designee. In-service will be completed by January 9 th ,2013. •□□□□□□□□All replacementbatteries to the ventilator machines will be observed by the respiratorytherapist on each shift that the batteries are charged and accessible. Staff will assure ambu bags are located ineach resident room who has a ventilator. •□□□□□□□□All Staff will beeducated on the procedure of in case of a power interruption and currentbatteries fail, and replacement batteries are not accessible. Including ambubag support by the Director of Nursing or designee by January 9 th ,2013 •□□□□□□□□All respiratorystaff will be trained on the procedure for observing and documenting each shiftassuring the replacement batteries are charged and accessible by the Directorof Nursing or designee January 9 th , 2013 •□□□□□□□□Generator load test will	

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	stationed in every room. On 12/13/12 at 2:45 a.m., LPN #12 indicated she worked on the ventilator unit during the outage. She indicated the vents started beeping due to low batteries. LPN #12 indicated she was going to call 911 if the ventilators failed. On 12/13/12 at 3:58 p.m., LPN #13 indicated she assisted on the ventilator unit during the outage. LPN #13 indicated the concentrator oxygen was replaced with portable oxygen after the generator stopped and they had to switch a resident to another ventilator due to a low batteries. She indicated one resident's oxygen saturation became low and the Respiratory Therapist addressed the issue by changing to the portable oxygen and repositioning the resident. On 12/13/12 at 4:10 p.m., CNA #14 indicated she was assisting the Respiratory Therapist on the ventilator unit, after the generator stopped, and the facility was dark. She indicated one resident asked to be suctioned, the Respiratory Therapist checked the resident and said he didn't need suctioning. She indicated another resident was coughing but the suction machine was down and the Respiratory Therapist assisted the resident.		be completed weeklyaccording to facility's policy and procedure by maintenance director **How the corrective action(s)will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place** •□□□□□□□□A "Crash cart checklist tool" will be completed daily to assure compliance is met threshold of 100% •□□□□□□□□A "Generator test tool" will be completed weeklyto assure compliance is met threshold of 100% •□□□□□□□□A "replacement battery CQI tool forventilator machines will be put into place daily times 2 weeks, weekly times4weeks, and then quarterly thereafter to assure compliance is met 100%. •□□□□□□□□The CQI team will review the datacollected. If threshold of 100% is not achieved, an action plan willbe developed, to ensure compliance **Compliance date:** January9th, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155159	A. BUILDING 00 B. WING	12/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	On 12/13/12 at 5:00 p.m., RT (Respiratory Therapist) #15, that worked during the outage was interviewed. The RT indicated, after the generator stopped, residents on concentrators had to be switched to liquid oxygen. She indicated Resident #D's oxygen saturation rates dropped into the 80s and she had to bag the resident until her saturation rates returned to the 90s. The RT indicated after about 45 minutes without power, vent alarms were activating due to low batteries. She indicated there were sprint battery packs in the respiratory storage room but they were not charged. She indicated "thankfully the electricity came back on before we had to start bagging (mechanically ventilating) residents." She indicated, after the outage, she placed sprint battery packs on all of the ventilator units and she also had some charging in the respiratory room. The RT indicated the sprint batteries were capable of running the ventilators for 4 to 6 hours. She indicated Resident #D had secretions and normally she would have suctioned the resident but the suction machines did not work after the generator stopped. The RT indicated Resident #D was able to cough forcefully enough to clear her airway. She indicated another resident asked to be suctioned but when she			

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	assessed him she felt he did not need to be suctioned. Finally, the RT indicated the nursing staff relied heavily on the respiratory staff to care for the residents with ventilators and tracheostomies. She indicated the nursing staff needed additional training in suctioning, mechanical ventilation (bagging), ventilator alarm parameters, tracheostomy care and infection control. On 12/14/12 at 4:10 p.m., the ADON (Assistant Director of Nursing) indicated, when she arrived at the facility, on 12/7/12, the lights were back on. She indicated the sprint battery packs she checked were fully charged. The ADON indicated she helped the Respiratory Therapist attach sprint battery packs to the ventilators. The Immediate Jeopardy that began on 12/7/12, was removed on 12/14/12, but non-compliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm, when the facility ensured the following: a back-up power source was available for ventilators and suction machines, monitoring was provided to ensure the back-up batteries were charged/accessible, and staff were inserviced on the procedures to be used during a power interruption.			

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	This Federal tag relates to Complaints IN00120969. 3.1-47(a)(6) 3.1-19(e)			