STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155159		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED 12/17/2012		
		100109	B. WIN			12/17/	2012
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE CLINTON ST		
SUMMIT CITY NURSING AND REHABILITATION		ND REHABILITATION			VAYNE, IN 46805		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG F0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE!)		DATE
1 0000							
	Complaints IN0 IN00120969. The partially extend Jeopardy. Complaint IN00 Federal/state de F309. Complaint IN00 Federal/state de F309 and F328.	his survey resulted in a ed survey-Immediate 0120966-Substantiated. fficiencies are cited at 0120969-Substantiated. fficiencies are cited at 0ecember 13, 14, 17, 2012 000079 or: 155159 100266160	F00	00			
	Census bed type	2 :					
	SNF: 65						
	Total: 65						
	Census payor ty Medicare: 5 Medicaid: 57 Other: 3 Total: 65	/pe:					

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

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

I35T11

TITLE

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

PRINTED: 01/08/2013 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155159	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/17/2012		
SUMMIT	PROVIDER OR SUPPLIER CITY NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETION		
	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.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 135T11

Facility ID: 000079

If continuation sheet

Page 2 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		155159	B. WING		12/17/2012		
SUMMIT		ND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 2940 N CLINTON ST FORT WAYNE, IN 46805				
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
F0309 SS=J	HIGHEST WELL Each resident must provide the services to attain practicable physipsychosocial we the comprehensicare. Based on intervifacility failed to means to summer when the call sy and prior to a redeficiency affect expired on the vicall system was was unable to us other residents. The Immediate 12/7/12, when the working. The Diffector of the Immediate 6:00 p.m. and the was removed on non-compliance scope and sever	ust receive and the facility in necessary care and in or maintain the highest ical, mental, and ill-being, in accordance with over assessment and plan of iew and record review, the ensure a resident had the on help, during a period estem was not operational sident's death. This sted 1 resident, who rentilator unit, when the not operational and who see the bell provided to (Resident #B) Jeopardy began on the call system stopped irector of rim Administrator and of Nursing were notified the Jeopardy on 12/13/12 at the Immediate Jeopardy in 12/14/12, but the remained at the lower ity of no actual harm with one than minimal harm.	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 regulation. Thisprovider respectfully request that the 2567 Plan of Correction be considered the Letter of Credible Allegation IDR will be Submitted for this deficiency F 309 Provide Care/Services for Highest we being It is the practice of this provide ensure that each resident must receive and the facility must provide the necessary care and services to attain of maintainth highest practicable physical, mental, and psychosocial well-being, inaccordance with comprehensive assessment a plan of care	of sign of the state of the sta		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 135T11

Facility ID: 000079

If continuation sheet Page 3 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155159		(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING (X3) DATE SURVE COMPLETED 12/17/2012			
		100100	B. WING	EET ADDRESS, CITY, STATE, ZIP CODE	12/11/2012
NAME OF I	PROVIDER OR SUPPLIE	3		0 N CLINTON ST	
SUMMIT	CITY NURSING A	ND REHABILITATION		RT WAYNE, IN 46805	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION DATE
TAG	on 12/13/12 at 9 entrance confered was interviewed at 3:35 a.m., the power, after a plus this caused a spid damaged electric including but not controls, electric and the call lighth The Administrate system stopped 3:50 p.m. and 1 initiated, bells were sidents, and act in the ventilator rooms. The Administrator in with remote aud purchased on 12 bells were collect on 12/7/12 at 4:0 On 12/13/12 at 12 (Respiratory The during the event #B's ventilator with resident's reconstruction of the resident's reconstruction with remote aud purchased on 12 the resident's reconstruction of the resident's reconstruction with remote aud purchased on 12/7/12 at 4:0 on 12/13/12 at 12 (Respiratory The during the event #B's ventilator with resident's reconstruction was passy-muir valvents.	election indicated, the call working, on 12/7/12 at 5 minute checks were rere passed out to full monitors were placed dependent resident ministrator indicated the repaired on 12/12/12. vided by the edicated the monitors, itory capabilities, were /8/12 at 2:27 p.m. and the eted from sister facilities on p.m. 11:00 a.m., RT erapist) #16 indicated, ng of 12/7/12, Resident was removed by a nurse, at quest and his as capped with a et so he could speak.	TAG	What corrective action(s)will accomplished for those residents found to have bee 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 practice and what corrective action will be taken • Residents residing in facility have thepotential to be affected by the alleged deficient practice • In-service will be conducted for staff on thefaci plan of action regarding call lighterruption procedures and replacement system by the Executive Director or designed January 9 th , 2013 • Call light system was replaced/repaired on12-12-12. What measures will be put place or what systemic changes you will make to ensure that the deficient practice does not recur	I be In Ine Ine Ine Ine Ine Ine Ine Ine In
		d he checked Resident #B 10 a.m. and Resident #B		plan of action regarding call li interruption procedures	-

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 135T11

Facility ID: 000079

If continuation sheet

Page 4 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING OO COMPLETE			COMPLETED
		155159	A. BUII B. WIN			12/17/2012
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	R				
SUMMIT	CITY NURSING A	ND REHABILITATION		2940 N CLINTON ST FORT WAYNE, IN 46805		
					(1/5)	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	ì ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
		t to be placed on the			andreplacement system by the	
	ventilator.	t to be placed on the			Executive Director or designee	
		1.45 11			January 9 th , 2013	
		d the call system was			• Facility will maintain	
		sident did not have a bell			manual bells toprovide to	
		dn't use it. He indicated			residents during interruption or	
	the nurse checke	ed the resident at 4:45			malfunction of call light system	
	a.m. and when the	ne Respiratory Therapist			Residents who cannot utilize the manual bellswill be	
	checked the resid	dent around 5:00 a.m., the			assessed by the licensed nurs	ina
	resident was pul	seless and unresponsive.			personnel for use of remote	9
		d he initiated CPR			adultmonitoring system	
	(Cardio Pulmona	ary Resuscitation) and			• Residents who cannot	
	there was no evi				verbalize summoning forhelp of	or
		n he was ventilating the			do not meet requirements for	
	resident.	in he was ventuating the			adult monitoring system, will b providedwith additional staff	e
	Testuent.				member for one: one services	
	0 10/10/10 + 1	1 20 4 1			until call light system isrestore	
		1:30 a.m., the Nurse			•Residents who require	
	Practitioner was				ventilator serviceswill be provide	ded
		esident #B had muscular			additional staff for one: one	
		extremely fragile			services until the call lightsyster is restored	em
	and was not able	e to move. She indicated			• • • • • • • • • • • • • • • • • • •	lo l
	he used a special	l call pad positioned by			within the facilitywill be observ	-
	his head to sumr	non help. The Nurse			every 15 minutes until the call	
	Practitioner indi	cated she did not think			light system is restored	
	the resident coul	d use a call bell to			The Executive Director	r
	summon help.				or designee isresponsible to	
					ensure follow up and complian	ice
	On 12/13/12 at 1	1:45 n m the			with the required procedure.	
	Housekeeping S	-			How the corrective action(s)	will
	1 .	*			be monitored to ensure the	
	interviewed. She indicated she did 15 minute monitoring of residents on the				deficient practice will not rec	ur,
		•			i.e., whatquality assurance	
		when the call system was			program will be put into plac	e
		e indicated, on 12/8/12 at			. "	
	· · · · · · · · · · · · · · · · · · ·	necked on Resident #B			• • • • • • • • • • • • • • • • • • •	
	and he was sleep	oing. She further indicated			tool" will be putinto place week	dy x

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 135T11

Facility ID: 000079

If continuation sheet Page 5 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155159		(X2) MUL A. BUILD		NSTRUCTION 00	(X3) DATE S COMPLI 12/17/2	ETED	
		155159	B. WING			12/1//	2012
	PROVIDER OR SUPPLIER	ND REHABILITATION		2940 N	DDRESS, CITY, STATE, ZIP CODE CLINTON ST VAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	move. The clinical recoreviewed on 12/2 indicated the resifacility for respit diagnoses which limited to, muscurespiratory failured dependence. The MDS (Minimal 12/1/12, indicated dependent for both dressing, hygiene Resident #B's conscored 14 out of of Mental Status) Respiratory Therefollowing: On 11/23/12 at 1 was admitted for require ventilator in ight when he word on a ventilator diagnostic care due to meet residents not timely manner." On 12/7/12 at 2::	mum Data Set), dated d the resident was totally ed mobility, transfer, e, and toileting. gnition was intact and he 15 on the Brief Interview rapy notes indicated the 1:30 a.m., the resident respite care and did not a support other than at			4 weeks and then quarterly thereafter to assure compliance met threshold of 100%. • The CQI team will revit the datacollected. If threshold not achieved, an action plan will be developed, to ensure compliance Compliance date: January9th 2013	ew is II	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 135T11

Facility ID: 000079

If continuation sheet

Page 6 of 16

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155159		(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	COM	TE SURVEY IPLETED 17/2012			
		100100	B. WING			1772012		
NAME OF	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP CO	ODE			
QLINANAIT		ND REHABILITATION	2940 N CLINTON ST FORT WAYNE, IN 46805					
				VATNE, IN 40005		_		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORE		(X5)		
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE		
1710	and a ventilator		1710	<u> </u>		DATE		
		55 a.m., "at 0500 A.M.						
	patient was four							
	_	(Cardiopulmonary						
		nitiated immediately with						
		ons. Tracheotomy cuff						
	_	e saline and Bag-mask						
		started c (with) 100%						
		PM (Liters Per Minute)						
	Flow. CPR cont							
		dical Services) arrival at						
	, ,	mately) 05:15 AM.						
		refused to wear ventilator						
		the night. Explained to						
		ortance of wearing the						
	ventilator at night	nt."						
	On 12/8/12 at 5:	32 a.m., Nursing Progress						
	Notes indicated	the resident was alert and						
	took a sip of wa	ter at approximately 4:45						
	a.m .and at appr	oximately 5:10 a.m., the						
	respiratory thera	pist entered the resident's						
	room and found							
	non-responsive	and not breathing.						
		-						
	The fifteen minu	ate monitoring log						
	indicated the res	sident was last checked at						
	5:00 a.m. by CN	JA #17.						
	On 12/17/12 at 1	12:15 p.m., CNA #17 was						
	interviewed. She	e indicated she checked						
	on Resident #B	around 5:00 a.m. and the						
	resident was aw	ake. She indicated about						
	10-15 minutes la	ater she heard the code						
	being called.							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 135T11

Facility ID: 000079

If continuation sheet

Page 7 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETE	
		155159	B. WIN			12/17/20	12
NAME OF P	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
SUMMIT	CITY NURSING A	ND REHABILITATION		2940 N CLINTON ST FORT WAYNE, IN 46805			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	OMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)		DATE
	Resident #B was provided to othe Resident #B had help at the time of the Immediate J	Jeopardy that began on					
	non-compliance scope and severi	remained at the lower ity of no actual harm with re than minimal harm,					
	ensure all reside summon help du	developed a plan to nts would be able to ring the interruption or he call light system.					
		relates to Complaints					
	IN00120966 and	_					
	3.1-37(a)						
	3.1-19(u)(1)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 135T11

Facility ID: 000079

If continuation sheet Page 8 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED					
1111212111	or conditions	155159				12/17/	
			B. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				CLINTON ST		
SUMMIT	CITY NURSING AN	ND REHABILITATION	FORT WAYNE, IN 46805				
(X4) ID		FATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX TAG	, The state of the	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
F0328	483.25(k)	ESC IDENTIFY TING INFORMATION)		IAG	,		DATE
SS=K	TREATMENT/CA The facility must of receive proper tree following special sinjections; Parenteral and er	nteral fluids; rostomy, or ileostomy care; re; ng;					
	Based on observer record review, the the emergency goduring a power of power alarms act and the inability for residents who maintain an oper potential for serie ventilator dependent the ventilator unioutage. (Resident #G and #H) The Immediate Journal of the Immediate Journal of the Immediate o	ation, interview and the facility failed to ensure enerator was operational putage, resulting in low tivating on ventilators to use suction equipment to required suctioning to an airway resulting in the residents residing on that the time of the power tts #B, #C, #D, #E, #F, deopardy began on the generator failed during outage. The Director of tim Administrator and tof Nursing were notified to Jeopardy on 12/13/12 at the Immediate Jeopardy	F032	28	The creation and submission of this Plan of Correctiondoes no constitute an admission by this provider of any conclusion set forthin the statement of deficiencies, or of any violation regulation. Thisprovider respectfully request that the 2567 Plan of Correction be considered the Letter of Credible Allegation IDR will be submitted for this deficient F 328 Treatment/Car for Special needs Itis the practice of this provider ensure that each residents receive propertreatment and conforthe following special service Injections, Parental andenternal fluids; colostomy, ureterostomy or ileostomy care; Tracheotomysuctioning;	t s of of ests on oney Technology	01/09/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 135T11

Facility ID: 000079

If continuation sheet

Page 9 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
		155159	B. WING 12/17/2012			
NAME OF B	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			2940 N	CLINTON ST	
SUMMIT CITY NURSING AND REHABILITATION					WAYNE, IN 46805	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE COMPLETION DATE
TAG		<u> </u>		TAG	Respiratory care; Foot care; a	
	was removed on 12/14/12, but non-compliance remained at the lower				prostheses.	iu
					produited.	
		ty of no actual harm with			What corrective action(s)will	be
	potential for mor	e than minimal harm.			accomplished for those	
					residents found to have been	1
	Findings include	:			affected by thedeficient	
					practice	
	On 12/13/12 at 9	:00 a.m., the Director of			•=====ResidentB no longer	
	Operations, who	had been acting as the			resides at the facility	
	Interim Adminis	trator since 12/11/12, was			• ResidentC, D, E, F, G,	
	interviewed.	,			and H. Facility does maintain	
	The Administrat	or indicated the facility			suction machines that will	
		the power company			operatewith battery back-up in	
	_	ing poles on 12/7/12 and			case of power interruption	4-
		facility would be shut			In-servicewill provided licensed nursing staff and	to
		strator indicated, before			Respiratory Therapy to	
		*			ensureoperation of the suction	
		er outage, the generator			machines during power	
	was tested on ful	I load and was			interruption by the Executive	
	functioning.				Directoror designee by Januar th , 2013.	y 9
		or indicated, when the			11, 2013.	
	1 1	turned off the power on			How will you identify	
	12/7/12 at 12:30	a.m., the generator			otherresidents having the	
	kicked in but fail	ed at 2:09 a.m. and the			potential to be affected by the	e
	facility was with	out any power until 3:35			same deficient practiceand	
	a.m The Admir	istrator indicated, cell			what corrective action will be	·
	phones were use	d, portable oxygen was			taken	
	obtained, flash li	ghts/head lights were			•=====Residents residing in t	he
	•	e ventilator batteries			facility have thepotential to be	IIC
	l ~	e ventilators. The			affected by the alleged deficier	nt
		dicated there were no			practice	
		s for the residents during			• In-servicewill provided	to
	the outage.				licensed nursing staff and	
		or further indicated a			Respiratory Therapy to ensureoperation of the suction	
					machines during power	
	back-up generate	or was installed on the			masimis during power	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 135T11

Facility ID: 000079

If continuation sheet Page 10 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			COMPLETED	
		155159				12/17/2012	
			B. WIN		ADDRESS OF STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
0	OLTY A HUDONIO AA	ID DELLABILITATION		2940 N CLINTON ST			
SUMMIT CITY NURSING AND REHABILITATION			FORT	VAYNE, IN 46805			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETIO	N
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	morning of 12/7	12 and the facility's			interruption by the		
	generator was scheduled for repairs.				ExecutiveDirector or designee	by	
	•	or provided a timeline of			January 9 th , 2013		
		•			• and an in-service will be		
		service training record			provided to licensednursing		
		staff were inserviced,			personnel and respiratory		
	after the incident	t, on 12/7/12 at 5:20 a.m.,			Therapy in case of a power		
	regarding the dis	aster plan for power			interruption andthe low battery indicator is alarming for the		
	outages and all r	urses on duty were			ventilator machines staff		
	_	checked off for bagging			willlocate replacement battery	for	
		al ventilation by hand)			the ventilator machines and		
	u 0	3			replace currentbattery followin	g	
	ventilator reside	nts.			procedure for battery		
					replacement. Replacement		
	On 12/13/12 at 1	0:30 a.m., during the tour			batteries are located in		
	of the ventilator	unit, five residents were			therespiratory office by the		
	identified as being	ng ventilator dependent.			Executive Director or designed	·	
		1:55 a.m., the suction			In-service will be completed by	′	
		rooms on the ventilator			January 9 th ,2013.		
	•				What measures will be putint	_	
		econd floor crash cart,			place or what systemic	0	
	were checked by				changes you will make to		
	Therapist and di	d not have battery			ensure that the		
	back-up and wor	ald not operate without			deficientpractice does not		
	electricity.	•			recur		
		2:00 p.m., two suction			1.000.		
		first floor were checked.			In-servicewill provided	to	
					licensed nursing staff and		
		hines would not operate			Respiratory Therapy to		
		ty and did not have a			ensureoperation of the suction		
	battery back-up.				machines during power		
					interruption by the		
	On 12/13/12 at 1	2:15 p.m., the			ExecutiveDirector or designee	by	
		dicated two suction			January 9 th , 2013		
					Facility will maintain	-4-	
		attery back-up had been			suction machines that will oper	·	
		ld arrive in the facility on			with battery backup in case of power interruption.		
	12/14/12.				• • • • • • • • • • • • • • • • • • •		
					•bervice will be		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 135T11

Facility ID: 000079

If continuation sheet Page 11 of 16

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	onstruction 00	(X3) DATE SURVEY COMPLETED
	155159	B. WING		12/17/2012
	PROVIDER OR SUPPLIER CITY NURSING AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES	STREET A 2940 N	ADDRESS, CITY, STATE, ZIP CODE CLINTON ST VAYNE, IN 46805	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
	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 the ventilator machines and replace currentbattery following procedure for battery replacement. Replacement batteries are located in therespiratory office by the Executive Director or designed In-service will be completed by January 9 th ,2013. In All replacementbatteries to the ventilator machines will observed by the respiratorytherapist on each signed accessible. Staff will assure ambu bags are located ineach resident room who has a ventilator. In All Staff will beeducated on the procedure of in case of power interruption and currentbatteries fail, and replacement batteries are not accessible. Including ambubags apport by the Director of Nursing or designee January 9 th ,20 mursing and documenting each shiftassuring the replacement batteries are charged and accessible by the Director of Nursing or designee January 9 th ,20 mursing	for g e. / es be hift and ed a g sing 013 be ach

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a. Building 00			COMPLETED		
155159		B. WING			12/17/2012		
NAME OF PROVIDER OR SUPPLIER SUMMIT CITY NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 2940 N CLINTON ST FORT WAYNE, IN 46805				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
					CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	
TAG	stationed in every On 12/13/12 at indicated she was unit during the events started be LPN #12 indicated 12/13/12 at indicated she as unit during the events to another vention with portable of stopped and the to another vention batteries. She in oxygen saturation Respiratory The by changing to repositioning the On 12/13/12 at indicated she was Respiratory The unit, after the gent facility was dark resident asked to Respiratory The resident and sais suctioning. She was coughing by	2:45 a.m., LPN #12 orked on the ventilator outage. She indicated the eping due to low batteries. ted she was going to call ators failed. 3:58 p.m., LPN #13 sisted on the ventilator outage. LPN #13 indicated roxygen was replaced sygen after the generator y had to switch a resident lator due to a low dicated one resident's on became low and the erapist addressed the issue the portable oxygen and e resident. 4:10 p.m., CNA #14 as assisting the erapist on the ventilator enerator stopped, and the k. She indicated one o be suctioned, the erapist checked the d he didn't need indicated another resident ut the suction machine he Respiratory Therapist		TAG	be completed weeklyaccording facility's policy and procedure maintenance director How the corrective action(s) be monitored to ensure the deficient practice will not reci.e., whatquality assurance program will be put into place • "Crash cart checklist tool" will be completed daily to assure compliance is met threshold of 100% • "Generator test tool" will be completed weeklyto assure compliance is met threshold of 100% • "A "Generator test tool" will be put into place daily time weeks, weekly times4weeks, at then quarterly thereafter to assure compliance is met 100%. • "The CQI team will revite datacollected. If threshold 100% is not achieved, an actic plan willbe developed, to ensurcompliance Compliance date: January9th 2013	pate g to by will cur, e t o ses 2 and sure ew of on ire	
	assisted the rest	uciit.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 135T11

Facility ID: 000079

If continuation sheet

Page 13 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	i 1	TE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00		PLETED	
		155159	B. WING			7/2012
NAME OF P	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP (CODE	
SUMMIT CITY NURSING AND REHABILITATION				N CLINTON ST T WAYNE, IN 46805		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO.	RRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	0 10/10/10 + 5					
	On 12/13/12 at 5	* '				
		erapist) #15, that worked				
		e was interviewed.				
		d, after the generator				
		ts on concentrators had to				
		quid oxygen. She				
		nt #D's oxygen saturation				
		to the 80s and she had to				
		until her saturation rates				
		0s. The RT indicated				
		inutes without power,				
	vent alarms were	e activating due to low				
	batteries.					
		ere were sprint battery				
		iratory storage room but				
	they were not ch	arged. She indicated				
	"thankfully the e	lectricity came back on				
	before we had to	start bagging				
	(mechanically ventilating) residents."					
	She indicated, af	ter 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 Re	esident #D had secretions				
	and normally she would have suctioned					
	the resident but t	he suction machines did				
	not work after th	e generator stopped. The				
	RT indicated Re	sident #D was able to				
	cough forcefully	enough to clear her				
	airway. She indicated another resident asked to be suctioned but when she					
	l		I			i

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 135T11

Facility ID: 000079

If continuation sheet

Page 14 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED		
155159			B. WIN	G		12/17/	2012
NAME OF PROVIDER OR SUPPLIER				STREET A	DDRESS, CITY, STATE, ZIP CODE		
					CLINTON ST		
SUMMIT CITY NURSING AND REHABILITATION				FORT V	VAYNE, IN 46805		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	FICIENCY) DATE	
	assessed him she felt he did not need to						
	be suctioned.						
		ndicated the nursing staff					
		the respiratory staff to					
	care for the resid	lents with ventilators and					
		She indicated the nursing					
		itional training in					
	suctioning, mech	nanical ventilation					
	(bagging), ventil	ator alarm parameters,					
	tracheostomy ca	re and infection control.					
	On 12/14/12 at 4	:10 p.m., the ADON					
	(Assistant Director of Nursing) indicated,						
	when she arrived	d at the facility, on					
	12/7/12, the lights were back on. She indicated the sprint battery packs she						
	checked were fu	lly charged. The ADON					
		ped 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.							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 135T11

Facility ID: 000079

If continuation sheet

Page 15 of 16

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

PRINTED: 01/08/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155159	(X2) MULTIPLE CC A. BUILDING B. WING	00	12/17	LETED 7/2012
SUMMIT		ND REHABILITATION	2940 N FORT V	ADDRESS, CITY, STATE, ZIP (CLINTON ST WAYNE, IN 46805	CODE	_
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	This Federal tag IN00120969. 3.1-47(a)(6) 3.1-19(e)	relates to Complaints				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 135T11

Facility ID: 000079

If continuation sheet

Page 16 of 16