STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155159	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit City Nursing and Rehabilitation	2940 N Clinton St Fort Wayne, IN 46805

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45243 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 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 [ROOM NUMBER] without knocking and announced after entering, who turned the light on?. CNA 5 entered room [ROOM NUMBER] 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 [ROOM NUMBER], 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. 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. 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. Resident 22's record review began on 11/12/24 at 2:45PM. Resident 22 diagnoses included 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. Resident 22's most recent comprehensive, Minimum Data Set (MDS), assessment dated [DATE] indicated the following: (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. In an interview, on 11/14/24 at 10:45 AM, the Administrator asked if staff were just knocking and announcing themselves. 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. No policy was made available at the time of exit. 3.1-3(p)(1)(t)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45243 Based on observation, interview, and record review the facility failed to ensure pain was managed for 1 of 1 resident reviewed. (Resident 22) Findings include: 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. 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 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. 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. 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. 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. 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. Resident 22's most recent comprehensive, Minimum Data Set (MDS), assessment dated [DATE] indicated the following: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Section J: Health Conditions Pain Assessment Interview was not completed. 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. 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. 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. Resident 22's pain concern on 11/12/24, nor attempts for pain relief were not documented. 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)