STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155159	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 04/04/2014

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
K010000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 04/04/14 Facility Number: 000079 Provider Number: 155159 AIM Number: 100266160 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Summit City Nursing and Rehabilitation was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two story facility with a basement was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor, in areas open to the corridor and battery operated	K010000	*The creation and submission of this Planof Correction does not constitute an admission by this provider of anyconclusion set forth in the statement of deficiencies, or of any violation ofregulation.* *This provider respectfullyrequests that the 2567 Plan of Correction be considered the Letter of CredibleAllegation*	

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

Any defiencystatement 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155159	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 04/04/2014
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 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
	smoke detectors in the resident rooms. The facility has a capacity of 93 and had a census of 89 at the time of this survey. All areas where the residents have customary access are sprinklered. The facility does have a shed providing facility services that was not sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/10/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155159	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 04/04/2014

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
K010025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 4 of 4 smoke barrier walls were protected to maintain the fire resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect all occupants. Findings include: Based on observations with	K010025	**Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice;** *·No Residents were affected.* *·All penetration to smoke barrierswall were appropriately repaired, immediately.* **·How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action(s) will be taken;** *·All resident have a potential tobe affected.* *·All penetration to smoke barrierwall were appropriately repaired.*	04/11/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155159	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 04/04/2014
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 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
	Environmental Supervisor on 04/04/14 from 2:10 p.m. to 2:36 p.m., at the following smoke barrier walls there were unsealed penetrations or penetrations sealed with an unrated material above the drop down ceiling: a. there was an unsealed penetration measuring three fourths inch around a phone line above the smoke barrier doors in the basement. b. there were two penetrations sealed with expandable foam above the smoke barrier doors entering the moving forward hall. Additionally, the dry wall had been pieced together leaving a three by five inch hole and a two inch gap around a section of conduit. c. there were 13 penetrations sealed with expandable foam then sporadically covered with fire caulk above the smoke barrier doors in the Cottage hall. Additionally, a section of drywall was broken leaving a one fourth inch gap between the two pieces. d. a penetration above the second floor smoke barrier doors was sealed with expandable foam. Measurement were provided by and the smoke barrier wall discrepancies were acknowledged by the Environmental Supervisor at the time of observations. 3.1-19(b)		**·What measures will be put intoplace or what systemic changes will be made to ensure that the deficientpractice does not recur;** *·Smoke barrier walls will beinspected for any penetration, monthly X 3 and quarterly thereafter.* *·All penetration will be repairedimmediately and finding submitted to CQI.* **·How the corrective action(s) willbe monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place; and** *·Smoke barriers walls will beinspected Monthly x 3 and quarterly thereafter.* *·All finding will be submitted toCQI team and reviewed for 100% compliance.* *·Any audit below the thresholdwill be corrected immediately* - - -	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155159	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 04/04/2014

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
			- **·By what date the systemic changeswill be completed.** *·Compliance date 4/11/2014*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155159	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 04/04/2014
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 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
K010130 SS=C	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, record review and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 50 of 50 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice affects all 89 residents. Findings include: Based on observation with the Environmental Supervisor on 04/03/14 during the tour from 12:55 p.m. to 2:45 p.m., each resident room had a battery operated smoke detector. Based on record review at 12:10 p.m., according to the "Monthly Smoke Detector Test" the batteries were replaced 02/05/13. The Environmental Supervisor acknowledged the batteries have not been replaced within the last year. 3.1-19(b)	K010130	**Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice;** *·No resident were affected.* *·All resident's room smokedetector's batteries were replaced immediately.* **·How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action(s) will be taken;** *·All residents have the potentialto be affected.* *·All resident rooms Smokedetectors batteries were replaced.* *·Resident's room smoke detectorwill be checked monthly and replace at least annually or as needed.* **·What measures will be put intoplace or what systemic**	04/11/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155159	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 04/04/2014
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 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
			changes will be made to ensure that the deficientpractice does not recur; *·Resident's room smoke detectorwill be checked monthly and replace at least annually or as needed* *·Finding will be presented to CQIteam and reviewed for 100%compliance.* **· How the corrective action(s) will bemonitored to ensure the deficient practice will not recur, i.e., what qualityassurance program will be put into place; and** *·Resident's room Smoke detectors willbe audited/tested monthly for proper working order.* *·All finding will be submitted toCQI team and reviewed for 100% compliance.* *·Any audit below the thresholdwill be corrected immediately* **Bywhat date the systemic changes will be completed.** *·ComplianceDate: 4/11/2014*	