STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155839	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT HEALTH AND LIVING	701 S MAIN ST SUMMITVILLE, IN 46070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: November 8, 9, 10 and 12, 2021. Facility number: 000373 Provider number: 155839 AIM number: 100288730 Census Bed Type: SNF/NF: 19 Total: 19 Census Payor Type: Medicaid: 17 Other: 2 Total: 19 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 17, 2021.	F 0000	Submission of this plan of correction shall not constitute or be construed as an admission by Summit Health & Living that the allegations contained in the survey report are accurate or reflect accurately the provision of care and service to the residents at Summit Health & Living. The facility requests the following plan of correction be considered its allegation of compliance. The facility also respectfully requests paper compliance due to the low scope of the tags cited.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives			

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 determin other safegaurds 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 disclo 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	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155839	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT HEALTH AND LIVING	701 S MAIN ST SUMMITVILLE, IN 46070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to prevent development of a pressure ulcer for 1 of 2 residents reviewed for pressure ulcers (Resident 10). Findings include: During an interview with Resident 10, on 11/8/21 at 1:41 p.m., she indicated she had just lost the scab on her right heel last week and it was tender and still hurt. They rubbed something on it but she didn't know what it was. She had a walking boot and doctor thought the pressure area was from the walking boot and that her foot may not had gotten back far enough in the boot. On 11/9/21 at 1:23 p.m., she sat across from the nurses station in her wheelchair, she had a pressure reducing boot on her right foot and a shoe on her left foot. During an observation of the resident's right heel, with the Wound Nurse, on 11/10/21 at 11:10 a.m., the area was the approximately size of a nickel it was partially yellow with the bottom of the wound darker in color (brown/gray). Inside the wound at the top was pink/red tissue (granulation tissue approximately the size of a pencil eraser. The Wound Nurse indicated, last week on 11/4/21, the scab or cap had come off of her heel and there was granulation tissue in the area. She also indicated the area was yellow and hard/calloused, and inside the wound at the top was granulation tissue. The pressure ulcer measured 2 centimeters (cm) x 2 cm. The granulation tissue measured 0.4 cm x 0.7 cm. She considered it to still be a Deep	F 0686	SH&L is requesting IDR for F 686 as the facility maintains appropriate care was given to resident # 10 to prevent pressure ulcer development. There is a known risk for pressure ulcer development when a medical device is used in the treatment of a fracture. Resident # 10 had a preventative skin assessment completed on 7/8/21 at 12:42 am and no concerns were identified with the resident's right heel. On 7/8/21 at 11:19 am, during routine assessment of the resident's heel a pressure area was identified. The resident's physician was notified and new orders for treatment were obtained. The resident and family were notified of the resident's area and new orders. The 2567 indicates upon resident interview 11/8/21 at 1:41 pm … "doctor thought the pressure area was from the walking boot and that her foot may not had gotten back far enough in the boot". The facility reviewed all orthopedic MD progress notes and there was no documentation that the MD thought the pressure area was	12/10/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155839	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT HEALTH AND LIVING	701 S MAIN ST SUMMITVILLE, IN 46070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Tissue Injury (DTI). The Nurse Consultant then observed the area and indicated it was unstageable, the treatment needed to be changed and to switch to heel protector boots. Resident 10's clinical record was reviewed on 11/9/21 at 1:30 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, essential hypertension, polyneuropathy is disease classified elsewhere, other chronic pain, other iron deficiency anemia's, morbid (severe) obesity due to excess calories and nondisplaced bimalleolar fracture of right lower leg, initial encounter for closed fracture. Her orders included, but were not limited to, skin prep to bilateral heels every shift with the start date of 9/15/21, range of motion (ROM) to right ankle every shift start 8/5/21, weekly skin assessment revised on 2/5/21. Heel protector to bilateral heels when in chair with the start date of 8/7/21. She had discontinued order that was started on 6/25/21 and discontinued on 7/7/21 that indicated standard of care (SOC) charting every shift for right ankle fracture. Check splint condition, neurovascular status of right lower extremity and pain control, etc. She had a discontinued order that was started on 7/2/21 and discontinued on 7/16/21 that indicated Controlled Ankle Motion (CAM) boot to right lower leg. May remove for ADL's and sleep if no pain. She had a discontinued order that was started on 7/7/21 and discontinued on 8/19/21, SOC charting every shift for right ankle fracture. Check boot condition, remove boot and inspect skin (unless		from her foot may not had gotten back far enough in the boot. The orthopedic progress note dated 7/1/21 indicated the resident had intact skin. Please see interviews with wound nurse as she describes the care the resident received daily in that nursing staff removed the boot for foot care and the nurse assessed her foot and heel area once a shift. We believe the 2567 failed to identify what the facility failed to do or did incorrectly to prevent the resident's pressure area. Resident # 10 Resident 10's right heel pressure area continues to improve. The 11/17/21 wound assessment right heel area was 2 cm x 2cm and unable to determine depth due to 100% firm eschar covering. Area was unstageable. A nursing note dated 11/21/21 documented by the wound nurse revealed the firm eschar covering has come off the heel wound exposing 75% epithelial tissue. MD was notified	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155839	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT HEALTH AND LIVING	701 S MAIN ST SUMMITVILLE, IN 46070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	resident has pain, then need to notify MD) neurovascular status of right lower extremity and pain control, etc. A quarterly Minimum Data Set (MDS), dated 5/31/21, indicated she was cognitively intact. She required limited assistance of one staff member for bed mobility, transfers, walking in her room and corridor. She required extensive assistance with one staff member for locomotion on and off the unit, dressing, toilet use and personal hygiene. She used a walker and a wheelchair. She was at risk for developing pressure ulcers. Her care plans included, but were not limited to the following: She had an actual fall with major injury, on 6/24/21, due to poor balance, unsteady gait while ambulating unassisted, initiated on 7/6/21. Her interventions included, but were not limited to, CAM boot to right lower extremity, remove for Activity for Daily Living (ADL's) and for sleep if no pain. Nero muscular assessment for left lower extremity every shift. Toe down weight bearing no more than 25%. She had a potential for pressure ulcer development related to DTI on her left heel from wearing her CAM boot following fracture. She was hesitant to get out of bed after her fracture so she stayed in bed most of the time which made her a high risk for pressure injuries, initiated on 7/12/21. Her goal was she would have intact skin, free of redness, blisters or discoloration by/through review date. Her interventions included, but were not limited to, assess/record/observe wound healing weekly. Measure length, width and depth where possible. Assess and document status of wound perimeter,		and new treatment order was obtained. The resident, and family were notified. New treatment order apply skin prep to the peri wound then apply sorbact cut to fit wound bed, cover with abdominal pad and wrap with Kerlix and change daily. Resident 10's wound assessment dated 11/24/21 documented the resident's right heel area was 1.2 cm x 1.4 cm with a 0.2 depth. Wound nurse staged the wound at Stage III and described the wound as 75% epithelial tissue with 25 % slough with no drainage noted. Peri wound intact skin no redness. New pressure relieving boots were ordered for the resident and placed on resident # 10 on 11/15/21. Resident # 10 was utilizing either heel protectors or floating of heels prior to onset of pressure area. Resident # 10 has a weekly preventative skin assessment completed ongoing and the facility will continue to complete weekly skin assessments on all residents. Resident # 10 had a preventative skin assessment completed on 7/8/21 at 12:42 am and no concerns were identified with the resident's right heel. On 7/8/21 at 11:19 am, during routine assessment of the resident's heel, a 2.0 cm x 2.5 cm deep tissue injury (DTI) was identified. The resident's physician was notified and new orders for treatment were obtained. Family was notified of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155839	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT HEALTH AND LIVING	701 S MAIN ST SUMMITVILLE, IN 46070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	wound bed and healing progress. Report improvements and declines to the MD. Follow facility policies/protocols for the prevention/treatment of skin breakdown. Remove CAM boot daily to check skin Date Initiated: 07/12/2021 Her nurses notes included, but were not limited to, and indicated the following: On 6/24/21 at 4:05 a.m., she was sitting on her bottom with head against bathroom door and her feet facing toilet, she indicated her knee gave out. Her outer right ankle started to swell and she had a knot on back of her head. On 6/25/21 at 12:45 a.m., she returned from a local emergency room. She had a closed bimalleolar fracture of right ankle and she had a leg splint to her right leg. Her right leg was elevated on a pillow. A risk for pressure ulcer assessment, dated 6/30/21 at 11:12 p.m., indicated she was at moderate risk for developing a pressure ulcer. The comment section indicated her skin was warm and dry and intact. Skin turgor was poor. Lotion and creams were applied by staff. On 7/1/21 at 2:29 p.m., she returned from orthopedic appointment. She had a new order to wear CAM boot, remove boot for ADL's and to sleep if she is having no pain. On 7/2/21 at 1:07 a.m., her pedal pulse was present, resident was able to wiggle toes. She rested comfortably in bed with boot on. On 7/2/21 at 2:53 p.m., CAM boot was on, she had good sensation to her foot and minimal swelling.		the resident's area and new orders. Skin care policy was updated to include information for residents with orders for a medical device. Currently no other residents have an order for a medical device. Residents at risk for pressure ulcer development have ordered interventions in place including, but not limited to, chair cushions, specialty beds, and pressure relieving mattress on bed. Observation was completed on 12/1/21, and each resident with an ordered intervention for pressure reduction had their ordered intervention. Each resident's ordered intervention is included on the resident's treatment administration record (TAR) the nurse visualizes the intervention and documents on the TAR every shift to ensure each resident has their ordered intervention in place. The Director of Nursing (DON) / designee currently audits preventive skin assessments on a weekly basis and will audit the resident's TAR on a weekly basis to ensure each resident has ordered intervention in place. These audits will continue ongoing with the preventative skin assessment audits. Any future orders for a medical device will be reviewed by the DON/designee by next business	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155839	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT HEALTH AND LIVING	701 S MAIN ST SUMMITVILLE, IN 46070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	She denied tingling or numbness. On 7/2/21 at 5:46 p.m., CAM boot was being worn. She could wiggle her toes and temperature was normal. On 7/3/21 at 1:16 a.m., her pedal pulse was present, she was able to wiggle toes. She rested comfortably in bed with boot on. On 7/3/21 at 10:26 a.m., CAM boot intact. Her foot was elevated on pillow. She was able to wiggle toes, extremity was warm to touch with positive pedal pulses. She denied any numbness or tingling. On 7/3/21 at 4:25 p.m., CAM boot intact. Her foot was elevated on pillow. She was able to wiggle toes, extremity was warm to touch with positive pedal pulses. She denied any numbness or tingling. On 7/4/21 at 2:36 a.m., the boot was in place to her right ankle and elevated on a pillow at that time. Pedal pulse were present. She was able to wiggle toes. She had minimal discomfort was noted and repositioning was effective. On 7/4/2021 at 10:24 a.m., CAM boot intact. Her foot was elevated on pillow. She was able to wiggle toes, extremity was warm to touch with positive pedal pulses. She denied any numbness or tingling. On 7/4/21 at 6:45 p.m., skin to right foot/leg was warm and dry. No skin irritation related to splint. She was able to move toes at will. Pedal pulse were palpable. Right lower extremity was elevated. On 7/5/21 at 12:18 a.m., skin to right foot/leg was		day to ensure proper orders for removal of medical device and inspection of the resident's skin. Nurses will be instructed to be attentive for development of any reddened areas associated with the wearing of a medical device to potentially prevent further skin breakdown. All residents have and will continue to have Braden assessment upon admission, and with each scheduled MDS. Nursing staff will continue to complete a weekly preventative skin assessment on all residents. Additionally, any residents with pressure injuries will be followed by NAR team weekly and all pressure injuries are also followed in quarterly QA meeting. CNA's re-educated on importance of proper skin care and importance of notifying the charge nurse immediately with any concerns with residents skin integrity. All residents identified with potential for skin breakdown will have health care plan to address skin care and individual interventions. POC Date:12/10/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155839	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT HEALTH AND LIVING	701 S MAIN ST SUMMITVILLE, IN 46070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	warm and dry. CAM boot was in place, no related skin irritation noted. She was able to move toes at will. Pedal pulse palpable. Right lower extremity was elevated. On 7/5/21 at 3:44 p.m., CAM boot had been on all day, except while she received her shower. She had a hard time transferring and not putting weight on her right foot. It was explained to her that she could put weight on the toe of her boot to support during transfers. Her toes moved easily and were warm to touch. No complaints of numbness or tingling. She took pain medication to control pain. On 7/5/21 at 6:23 p.m., CAM boot was on right foot on a pillow. She was able to wiggle toes and normal temperature. On 7/6/21 at 1:41 a.m., she complained of right foot aching. CAM boot on but loosened, which seemed to help. Pedal pulses were present and resident could move toes. On 7/6/21 at 3:43 p.m., CAM Boot was on, resident had Fentanyl patch for pain control. She stayed in bed and didn't want to move much except to be changed. She slept a lot. She was able to move toes, they were warm to touch with no complaints of numbness or tingling. On 7/6/21 at 9:20 p.m., CAM boot worn. She was able to wiggle her toes. She had normal skin temperature. On 7/7/21 at 12:52 a.m., She complained of her right foot aching. CAM boot on but loosened, which seemed to help. Pedal pulses were present and resident could move toes.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155839	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT HEALTH AND LIVING	701 S MAIN ST SUMMITVILLE, IN 46070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	On 7/7/21 at 1:41 p.m., CAM boot intact, her foot was elevated on a pillow. She was able to wiggle her toes, extremity was warm to touch with positive pedal pulses. She denied any numbness or tingling. skin surfaces were intact. On 7/7/21 at 6:16 p.m., CAM boot intact, her foot was elevated on a pillow, she was able to wiggle toes, extremity was warm to touch with positive pedal pulses. She denied any numbness or tingling. Skin surfaces are intact. Lotion was applied to dry areas. Bruising to right lateral foot and ankle. On 7/8/21 at 12:56 a.m., she complained of her right foot aching like a tooth ache. CAM boot on, her pedal pulses were present and she could move her toes. A risk for pressure ulcer assessment, dated 7/8/21 at 12:42 a.m., indicated she was at mild risk for developing pressure ulcers. Comments section indicated her skin was warm and dry to touch with no tenting. On 7/8/21 at 11:19 a.m., CAM boot intact, her foot was elevated on a pillow, she was able to wiggle toes, extremity was warm to touch with positive pedal pulses. She denied any numbness or tingling. Skin surfaces were intact. Skin care was given with skin surfaces intact. Lotion applied to dry areas. Bruising to right lateral foot and ankle remained. On 7/8/21 at 11:19 a.m., bruising to medial foot and ankle as well. Noted 2 cm x 2.5 cm DTI post heel. New order received for skin prep every shift. The back of CAM boot padded. 7/8/21 at 6:14 p.m., CAM boot intact. She			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155839	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT HEALTH AND LIVING	701 S MAIN ST SUMMITVILLE, IN 46070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	complained frequently for boot to be loosened and readjusted. No edema noted and pedal pulse were present. Skin prep applied to heel. During an interview with the Wound Nurse, on 11/12/21 at 10:35 a.m. she indicated they ordered new boots for her. They would document on the nurses notes for monitoring her skin each shift. During an interview with the Wound Nurse, on 11/12/21 at 1:30 p.m., she indicated the resident did not have an injury per the Preventative Skin Care Measures with Braden Scale, dated 6/30/21 and the orthopedic office visit on 7/1/21, indicated no injury. She returned with the CAM boot 7/1/21. On 7/8/21 there was no injury on the skin assessment in the morning and in the evening with removal, the pressure ulcer was there on 7/8/21. They removed the boot each shift with care. The order that indicated CAM boot to right lower leg may remove for ADLs and sleep if no pain. Touch Down Weight Bearing (TDWB) which meant no more than 25% just to maintain balance every shift for fractured right ankle was what they used to check her heel, took off the boot and did a skin assessment. The CNA would take it off and clean her foot and she would do the assessment. She completed the treatment daily but measured the pressure ulcer on Wednesdays. A 7/26/21 revised policy titled, "Wound Program Policy and Procedures," provided by the Administrator, on 11/12/21 at 3:51 p.m. indicated the following: "Policy: Wound Care Program: It is the practice of Essential Senior Health and Living to provide a comprehensive approach to preservation and protection of each resident's skin integrity while under out care...Identification of Risk for Pressure Injury: The Braden Scale will be used as one tool to assist in identification of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155839	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT HEALTH AND LIVING	701 S MAIN ST SUMMITVILLE, IN 46070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	each resident's risk for pressure injury... With the purpose being to identify causative/contributing factors to develop pressure injuries... Because anyone over the age of 65 years should be considered at some degree of risk, it is important to note that anyone 65 years or older should be upgraded to next level of overall risk, per Braden Scale guidelines...." 3.1-40(1)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, record review, and interview, the facility failed to ensure a resident did not receive an antipsychotic medication without indication, failed to identify targeted behaviors to support the use of antipsychotic medication, and failed to initiate person-centered care plan interventions, for 2 of 3 residents reviewed for dementia care (Residents 16 and 8). Findings include: 1. During an observation, on 11/9/21 at 1:20 p.m., Resident 16 was lying in bed. On 11/10/21 at she was lying in bed. On 11/12/21 at 9:59 a.m., she was lying in bed. Her clinical record was reviewed on 11/9/21 at 1:24 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, delusional disorder, major	F 0744	Resident # 16 Resident # 16's psychoactive medications were reviewed on 11/23/21 by the IDT (interdisciplinary team) including MDSC (minimum data set coordinator), DON (director of nursing), Social Services staff, Psych NP (nurse practitioner), and Administrator. The residents Zoloft was due for a gradual dose reduction, and the NP reduced the Zoloft 25 mg daily. IDT discussed resident's behaviors and determined her target behaviors for the use of antipsychotic med are verbal and physical aggression. Resident # 16's healthcare plans (HCP) were updated to include target behavior and individualized interventions. Direct care nursing	12/10/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155839	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT HEALTH AND LIVING	701 S MAIN ST SUMMITVILLE, IN 46070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	depressive disorder, mood (affective) disorder, anxiety disorder due to known physiological condition, and dementia with behavioral disturbance. Current physician orders included, but were not limited to, the following: a. Donepezil (Alzheimer's disease therapy) 10 MG (milligram), one tablet one time a day for dementia, order date 1/11/21. b. Sertraline (antidepressant) 50 MG, one tablet one time a day related to anxiety disorder due to known physiological condition, order date 5/25/21. c. Zyprexa (antipsychotic) 2.5 MG, give 2.5 MG two times a day related to mood (affective) disorder and dementia with behavioral disturbance, order date 8/5/21. d. Behavior/intervention/side effect progress note every shift for medications Zoloft and Zyprexa, order date 8/17/21. An 10/11/21 quarterly MDS (Minimum Data Set) assessment indicated she had severe cognitive impairment. No moods or behaviors had been identified. She had received an antipsychotic and antidepressent everyday during the assessment period. The antipsychotic had been received on a routine basis and a GDR (gradual dose reduction) had not been attempted. A current care plan, initiated on 1/14/21 and revised on 8/24/21, indicated she used psychotropic medications related to behavior management and delusional disorder. Interventions included, but were not limited to, observe and record occurrence of for target behavior symptoms (specify: pacing, wandering, disrobing, inappropriate response to verbal		staff were interviewed to determine best individual interventions for resident # 16. A list was developed including each resident on psychoactive meds that includes target behaviors and individualized interventions. This list will be maintained at the nurse's station and updated as needed by the DON/designee. All staff will have access to the information regarding each resident's target behaviors and interventions. Resident # 16's HCP will be reviewed at least quarterly, or more often as indicated with updates to target behaviors, goals, and interventions completed as indicated. Care plan IDT meetings will have discussion on resident's target behaviors and individualized interventions. Resident # 8 Resident # 8's psychoactive medications were reviewed on 11/23/21 with the IDT including MDSC, DON, Social Services staff, Psych NP, and Administrator. IDT discussed resident behaviors an determined the resident's target behaviors for the use of antipsychotic medications are refusal of care, verbal and physical aggression.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155839	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT HEALTH AND LIVING	701 S MAIN ST SUMMITVILLE, IN 46070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	communication, violence/aggression towards staff/others), and document per facility protocol, initiated 1/19/21. A current care plan, initiated 1/18/21 and revised on 2/27/21, indicated the resident had a diagnosis of anxiety and may have behaviors related to anxiety. Interventions included, but were not limited to, provide 1:1 with resident for a short time until she has calmed and provided assurance that she was safe and staff would remain in the building at all times, both revised on 1/27/21. A current care plan, initiated on 1/18/21, indicated the resident had delirium or an acute confusional episode related to acute disease process Alzheimer's disease and delusional disorder. Interventions included, but were not limited to, staff would use the resident's preferred name, identify themselves at each interaction, face the resident when speaking and make eye contact, reduce distractions - turn off television, radio, close door, provide her with necessary cues - stop and return if agitated, revised on 1/27/21. A Behavior Charting note, dated 9/13/21 at 3:31 p.m., indicated she had refused to allow oxygen saturation to be obtained and wouldn't allow the nurse to administer an intradermal injection to test for tuberculosis. Prior to the behavior she had been sitting in a chair or lying in bed. Staff attempted to talk her into allowing the nurse and another staff member to obtain vital signs. Intervention was not effective. A Behavior Charting note, dated 9/14/21 at 11:09 a.m., indicated she had refused to allow blood draw, listening to her lung sounds, and treatment to her head. Prior to the behavior she had been sitting in wheelchair after breakfast. Staff		Resident # 8's HCP's were updated to include target behavior and individualized interventions. Direct care nursing staff were interviewed to determine best individual interventions for Resident # 8. A list was developed including each resident on psychoactive meds that includes target behaviors and individualized interventions. This list will be maintained at the nurse's station and updated as needed by the DON/designee. All staff will have access to the information regarding each resident's target behaviors and interventions. Resident # 8's HCP will be reviewed at least quarterly, or more often as indicated with updates to target behaviors, goals, and interventions completed as indicated. Care plan IDT meetings will have discussion on resident's target behaviors and individualized interventions. HCP target behaviors and interventions will be updated as indicted by the MDSC. Staff in-serviced by 12/12/21 regarding target behaviors, interventions, and location of resident specific lists. All residents' medications are and will continue to be reviewed on a monthly basis by the consultant pharmacist. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155839	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT HEALTH AND LIVING	701 S MAIN ST SUMMITVILLE, IN 46070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	attempted talking to her to reassure that it doesn't hurt different people. The intervention was not effective. A Behavior Charting note, dated 9/22/21 at 7:44 p.m., indicated the resident had yelled at staff trying to obtain oxygen saturation and listen to her lung sounds. Staff attempted to redirect one on one. The intervention was not effective. A Behavior Charting note, dated 9/26/21 at 4:41 p.m., indicated resident had hit staff during care. Prior to the behavior she was awake after napping. Staff attempted one on one and redirecting. The behaviors had stopped once she was up. An IDT (Interdisciplinary Team) progress note, dated 9/29/21 at 10:00 a.m., indicated the DON (Director of Nursing), SSD (Social Service Director), Psych NP (Nurse Practitioner), Consultant Pharmacist, and the Administrator had met to discuss the resident's psychoactive medications. Resident was taking Zoloft 50 MG daily, which is due for review in November, and Zyprexa 2.5 MG twice a day for behavioral and psychological symptoms of dementia, which is due for review in January. Resident had improved since initiation of Zyprexa on 8/6/21. She had allowed blood to be drawn on two occasions, and participated more willingly in activities. Resident was followed by Psych NP. Team made no new recommendations. A Behavior Charting note, dated 10/2/21 at 12:06 a.m., indicated the resident had refused to allow vital signs to be obtained. Prior to the behavior she had been lying in bed. Staff reapproached several times. The intervention was not effective. A Behavior Charting note, dated 10/2/21 at 3:49		behavior/psychoactive medication IDT meets monthly on all residents with MD/NP orders for psychoactive medications. Each resident with psychoactive medications will have review of behaviors, interventions, and effectiveness of medications at each monthly behavior IDT meeting. Each residents' medications, behaviors, and interventions will be discussed for appropriateness. DON/designee will be responsible for updating list of behaviors/interventions for all staff. MDSC/designee will be responsible for updating residents HCP's for target behaviors and individualized interventions. Quarterly QA meeting review facility psychoactive medication use, % of categories uses, and trends and will continue to do so on an ongoing basis. POC Date: 12/10/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155839	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT HEALTH AND LIVING	701 S MAIN ST SUMMITVILLE, IN 46070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	p.m., indicated the resident had been resistant to allowing the nurse to obtain her oxygen saturation level, but was able to obtain her temperature and listen to her lungs. Prior to the behavior she had been sitting in her room. A Behavior Assessment, dated 10/24/21, indicated no behaviors. An IDT progress note, dated 10/26/21 at 10:15 a.m., indicated the DON, MDS Coordinator, consultant pharmacist, Psych NP, social service/activity staff, and Administrator met to discuss residents psychotropic medications. Resident was taking Zoloft 50 MG, due for GDR in November, and Zyprexa 2.5 MG twice a day, due for review in January She had been more pleasant and participatory in activities since Zyprexa had started. If she didn't recognize someone because of a mask she would yell I don't know you, but overall more pleasant. Team made no new recommendations. Is followed by Psych NP. Diagnoses included dementia with behavioral disturbance, anxiety, and major depressive disorder. A Behavior Charting note, dated 10/27/21 at 12:14 p.m., indicated she had refused to allow vital signs to be obtained. Prior to the behavior she had been lying in bed. Staff attempted to reapproach her. The intervention was not effective. A Behavior Assessment, dated 10/29/21, indicated no behaviors, mood pleasant and cooperative with care. A Behavior Charting note, dated 11/9/21 at 3:06 p.m., indicated she would not allow the nurse to obtain her blood pressure, oxygen saturation, or pulse. Prior to the behavior she had been in her			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155839	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT HEALTH AND LIVING	701 S MAIN ST SUMMITVILLE, IN 46070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	room, sitting in her wheelchair. Staff attempted to ask her how she was feeling and if her arm hurt, and tried to explain why it was important for her vital signs to be obtained. The interventions were not effective. A Behavior Charting note, dated 11/11/21 at 10:56 a.m., indicated the resident had refused shower and washing her face that morning. Staff attempted one on one and redirecting. The interventions were not effective. During an interview, on 11/12/21 at 10:01 a.m., QMA (Qualified Medication Aide) 7 indicated the resident sometimes had behaviors, didn't like to have her blood pressure taken and refused care. The intervention used was to reapproach to see if her mood had changed. She was not aware of a list of targeted behaviors or behaviors that would support the use of psychotropic medications that needed to be monitored. They just report any behavior a resident had. During an interview, on 11/12/21 at 10:11 a.m., QMA 12 indicated the resident sometimes refused to allow her blood pressure to be checked and if other residents were around her she would tell them to get away. Intervention of talking to her usually worked. Charge Nurse was notified about any behaviors that had occurred, she was not aware of any specific behaviors related to the use of psychotropic medications that needed to be monitored. During an interview, on 11/12/21 at 10:19 a.m., LPN 5 indicated the resident frequently refused showers and having vital signs taken. Intervention that worked was to reapproach. Behaviors are documented under Behavior Charting note in the clinical record. No specific or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155839	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT HEALTH AND LIVING	701 S MAIN ST SUMMITVILLE, IN 46070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	target behaviors to monitor related to psychotropic medication use, they monitor all behaviors. 2. During an observation, on 11/8/21 at 10:37 a.m., Resident 8 was sitting in her room. On 11/10/21 at 10:33 a.m., she was sitting in a recliner. On 11/12/21 at 10:00 a.m., she was lying in bed under the covers. Her clinical record was reviewed on 11/10/21 at 2:30 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, unspecified mood (affective disorder, major depressive disorder, violent behavior, and vascular dementia with behavioral disturbance. Current physician orders included, but were not limited to, the following: a. Refer to psych services, order date 6/29/21. b. Sertraline 50 MG tablet, one tablet one time a day related to major depressive disorder, order date 8/24/21. c. Seroquel (antipsychotic) 50 MG tablet, one tablet at bedtime for agitation, order date 10/26/21. d. Depakote (mood stabilizer) delayed release 125 MG tablet, one tablet two times a day related to violent behavior and restlessness and agitation, order date 10/26/21. e. Depakote delayed release 250 MG tablet, one tablet two times a day related to violent behavior and restlessness and agitation, order date 10/26/21. f. Behavior/intervention/side effect progress note every shift for medications Seroquel, Depakote,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155839	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT HEALTH AND LIVING	701 S MAIN ST SUMMITVILLE, IN 46070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	and Zoloft, order date 10/29/21. A 9/13/21 quarterly MDS assessment indicated she had severe cognitive impairment. Moods related to little interest or pleasure in doing things and trouble falling asleep or staying asleep, or sleeping too munch had occurred nearly everyday. No behaviors had been exhibited. She had received an antipsychotic and antidepressent everyday during the assessment period. The antipsychotic had been received on a routine basis and a GDR had not been attempted. A current care plan, initiated on 1/19/21 and revised on 2/23/21, indicated she used psychotropic medications related to behavior management, potential for injury to self or others, and dementia with behavioral disturbance. Interventions included, but were not limited to, observe and record occurrence of for target behavior symptoms (specify: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others),and document per facility protocol, initiated 1/19/21. A current care plan, initiated on 1/19/21 and revised on 11/8/21, indicated she was resistive to care related to mood disorder, may refuse showers or incontinence care, and would allow care when she decided she wanted it. The goal, with a 12/30/21 target date, indicated she would cooperate with care through next review date. Interventions initiated on 1/19/21 included, but were not limited to, clear explanation of all care activities to have been given as they occurred during each contact, if she resisted ADL's (activities of daily living), reassure her, leave and return 5-10 minutes later and try again, provide consistency in care to promote comfort with			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155839	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT HEALTH AND LIVING	701 S MAIN ST SUMMITVILLE, IN 46070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	ADL's, maintain consistency in timing of ADL's, caregivers and routine, as much as possible. A current care plan, initiated on 2/23/21 and revised on 8/24/21, indicated she used psychotropic medications related to diagnoses of unspecified mood disorder, irritability and anger, vascular dementia with behavioral disturbance. Seroquel was GDR on 8/24/21, Depakote GDR contraindicated on 9/22/20, and Zoloft started on 7/15/21 and increased on 8/24/21. Interventions, initiated on 2/23/21, included, administer medications as ordered, observe and document for side effects and effectiveness, consult with pharmacy and medical doctor to consider dosage reduction when clinically appropriate, and observe, record, and report to medical doctor as needed, side effects and adverse reactions of psychoactive medications. An IDT (Interdisciplinary Team) progress note, dated 9/30/21 at 10:00 a.m., indicated the DON, SSD, Psych NP, Consultant Pharmacist, and the Administrator had met to discuss the residents psychoactive medications. She was taking Depakote 250 MG twice a day., Seroquel 25 MG at bedtime, due for review in February, and Zoloft 50 MG daily, due for review in January for depression. Resident diagnoses included dementia with behavioral disturbances, mood disorder, major depression and insomnia. Team discussed resident's behaviors at length included biting and hitting. Psych NP recommended increasing resident's Depakote to 375 MG twice a day. New order by NP for Depakote increase. A Behavior Charting note, dated 10/3/21 at 12:07 a.m., indicated she had behavior of combative with care, prior to the behavior she had been lying in bed, staff attempted to reapproach and talking			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155839	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT HEALTH AND LIVING	701 S MAIN ST SUMMITVILLE, IN 46070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	resident through what staff wanted to do and why. The interventions were not effective. A Behavior Charting note, dated 10/3/21 at 9:18 p.m., indicated behavior that she attempted to bite and scratch with bedtime care, staff attempted to redirect the resident one on one. The intervention was not effective. A Behavior Charting note, dated 10/4/21 at 9:30 p.m., indicated behavior that she yelled and cursed during a shower, scratched and attempted to bite staff. Prior to the behavior in the shower, she had been sitting in her room. Staff attempted to calmly talk with the resident. The intervention was not effective. A Behavior Charting note, dated 10/5/21 at 5:26 a.m., indicated behavior that she hit and cursed during care. Prior to the behavior she had been resting quietly in bed. Staff tried to talk with her during care to distract her and turned music on. The interventions were not effective. A Behavior Charting note, dated 10/5/21 at 9:51 p.m., indicated behavior that she was uncooperative with bedtime care and hit at CNA (Certified Nursing Assistant). Staff attempted to redirect her one on one. The intervention was not effective. A Behavior Charting note, dated 10/7/21 at 3:44 p.m., indicated behavior that she had been hitting, biting, scratching and cursing during her shower. Staff attempted to talk to her and reassure they would be done soon. The intervention was not effective. A Behavior Charting note, dated 10/8/21 at 9:28 p.m., indicated behavior that she had been hitting,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155839	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT HEALTH AND LIVING	701 S MAIN ST SUMMITVILLE, IN 46070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	cursing and scratched staff during bedtime care. Prior to the behavior she had been resting quietly in bed. Staff attempted to turn music on, tried different staff members, tried to talk and distract her during care. The interventions were not effective. A Behavior Charting note, dated 10/9/21 at 10:48 a.m., indicated behavior that she had been aggressive with staff during ADL care. Staff attempted one on one and redirecting, the interventions were not effective. A Behavior Charting note, dated 10/9/21 at 8:06 p.m., indicated behavior of swinging her arms and attempted to hit staff during bedtime care. Prior to the behavior she had been resting quietly in in her recliner watching television. Staff attempted talking with her to distract her and turned Christian music on. The interventions were not effective. A Behavior Charting note, dated 10/15/21 at 8:26 p.m., indicated behavior of hitting, scratching, pinching, and trying to bite during bedtime care. Staff attempted to redirect her with one on one. The intervention was not effective. A Behavior Charting note, dated 10/17/21 at 9:40 p.m., indicated behavior of digging her fingernails into a CNA's arms during bedtime care. Prior to the behavior she had been listening to Alan Jackson sing. Staff attempted to redirect her with one on one and signing along with her. The interventions were not effective. A Behavior Charting note, dated 10/18/21 at 6:48 p.m., indicated behaviors during a shower included screaming and digging fingernails into CNA's arm. Staff attempted redirection and one on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155839	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT HEALTH AND LIVING	701 S MAIN ST SUMMITVILLE, IN 46070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	one. The interventions were not effective. A Behavior Charting note, dated 10/21/21 at 9:23 p.m., indicated behaviors during a shower included scratching and trying to bite and hit CNA's. Staff attempted to redirection and one on one. The interventions were not effective. A Behavior Charting note, dated 10/22/21 at 9:42 p.m., indicated behavior during care of hitting and trying to bite staff. Prior to the behavior she had been resting quietly in her chair. The staff attempted to talk with her to distract her and turned Christian music on. The interventions were not effective. A Behavior Charting note, dated 10/23/21 at 9:50 p.m., indicated she had been combative during care. Prior to the behavior she had been sitting in her recliner listening to music. Staff attempted to talk with her and distract her, music was already playing, different staff tried to reapproach the resident. The interventions were not effective. A Behavior Charting note, dated 10/24/21 at 9:28 p.m., indicated the resident had been resting in bed, during bed check she required incontinence care, was scratching, biting, cursing, kicking, and yelling during care. Staff attempted to talk with her and distract her, she was given her baby doll to hold, and Christian music was turned on. The interventions were not effective. A Behavior Charting note, dated 10/25/21 at 11:07 p.m., indicated behavior of refusing shower and kicking and cursing staff during bedtime care. Prior to the behavior she had been resting in her room. Staff attempted different staff members to approach her about taking a shower and she continued to refuse.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155839	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT HEALTH AND LIVING	701 S MAIN ST SUMMITVILLE, IN 46070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	A nurse progress note, dated 10/28/21 at 2:14 p.m., indicated the resident had been seen by the NP on 10/26/21. A new order had been received to increase Seroquel to 50 MG due to increased agitation and aggression. A Behavior Charting note, dated 10/31/21 at 11:10 p.m., indicated behavior of hitting and scratching staff during bedtime care. Staff attempted to redirect resident one on one. The intervention was not effective. A Behavior Charting note, dated 11/4/21 at 7:43 p.m., indicated behavior of hitting and scratching staff during a shower. Staff attempted to resident and one on one. The interventions were not effective. During an interview, on 11/12/21 at 10:01 a.m., QMA 7 indicated the resident has behaviors some days of hitting and screaming if she didn't want incontinent care provided, interventions to coax her with coffee, she also liked bananas and talking about her dog. The nurse asked CNA's and QMA's if the resident had any behaviors and put information in the computer. She was not aware of a list of targeted behaviors or behaviors that would support the use of psychotropic medications that needed to be monitored. They just report any behavior a resident had. During an interview, on 11/12/21 at 10:11 a.m., QMA 12 indicated the resident would once in a while scratch or curse staff, they leave her alone and try again, that usually works, she likes to listen to Alan Jackson and they turn that on for her. Charge Nurse was notified about any behaviors that had occurred, she was not aware of any specific behaviors related to the use of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155839	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT HEALTH AND LIVING	701 S MAIN ST SUMMITVILLE, IN 46070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	psychotropic medications that needed to be monitored. During an interview, on 11/12/21 at 10:19 a.m., LPN 5 indicated the resident had behaviors of smacking, digging her fingernails in staff's arms, and name calling. Interventions included trying to redirect her or one on one, if those weren't effective, then approach later. Behaviors are documented under Behavior Charting note in the clinical record. No specific or target behaviors to monitor related to psychotropic medication use, they monitor all behaviors. During an interview, on 11/12/21 at 2:03 p.m., the Administrator indicated behaviors were reviewed in monthly behavior meeting, IDT progress notes, and sometimes in other progress notes. Staff were trained to leave then reapproach or try another caregiver if behaviors occurred. The facility did not have a policy related to behaviors or dementia care. During an interview, on 11/12/21 at 2:04 p.m., the DON indicated the medication order included the behavior being monitored. Review of a current facility policy, titled "COMPREHENSIVE CARE PLANS," with a revised date of 10/2017 and provided by the Administrator on 11/12/21 at 3:51 p.m., indicated "Policy: The Facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident's rights and that includes measurable objectives and time frames to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment...1. The services that are to be furnished to attain or maintain the resident's highest practicable			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155839	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT HEALTH AND LIVING	701 S MAIN ST SUMMITVILLE, IN 46070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	physical, mental and psychosocial well-being...." 3.1-37(a)			
F 9999 Bldg. 00	410 IAC 16.2-3.1-14 Personnel (u) In addition to the required in-service hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule is not met as evidence by: Based on interview and record review, the facility failed ensure annual dementia training was completed for 5 of 5 employees reviewed for required annual training (CNA 31, RN 37, QMA 35, Dietary Aide 38 and LPN 39). Findings include: Employee files were reviewed on 11/9/21 at 9:30 a.m. and indicated the following: An In-service record, dated 7/13/21, indicated RN 37, Dietary Aide 38 and QMA 35 received 1 hour of annual dementia training. CNA 31 and LPN 39 had not received annual dementia training.	F 9999	A policy was developed to ensure that staff who have regular contact with residents receive dementia training within six months of hire, or within 30 days for staff assigned to a dementia special care unit, and three hours annually. Arrangements were made with the MSW dementia unit director of a sister facility to provide the required dementia training on an annual basis. An all staff mandatory dementia in-service is scheduled for 12/6/21. The facility will provide three different hour long sessions, and the presentation will be recorded if any make up sessions are necessary. Dementia in-service sessions will be scheduled with the MSW dementia unit director for 2022 in order to meet the dementia in-service requirement. Administrator/designee will monitor staff attendance to ensure all staff have the required training. All staff educated at morning meetings & will be educated during in-services on 12/6/21 on importance of dementia training. POC Date: 12/10/21	12/10/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155839	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT HEALTH AND LIVING	701 S MAIN ST SUMMITVILLE, IN 46070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	On 11/10/21 at 2:05 p.m., the Administrator indicated she thought that was the only dementia training there was. On 11/10/21 at 4:11 p.m., the DON indicated they did not have a policy related to dementia training.			