STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155839	A. BUILDING -- B. WING	12/01/2021

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/01/21 Facility Number: 000373 Provider Number: 155839 AIM Number: 100288730 At this Emergency Preparedness survey, Summit Health and Living was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 34 certified beds. At the time of the survey, the census was 19. Quality Review completed on 12/02/21	E 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.	
E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at			

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

Any deficiencystatement 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.

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	§482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c)			

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	of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that is based on the emergency plan accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Director of Plant Operation and Administrator on 12/1/21 between 11:15 a.m. and 12:50 p.m., the provided Emergency Preparedness Plan (EPP) did not contain a training and testing program. Based on interview at the time of record review then again at the exit conference, the Director of Plant Operation and Administrator stated the facility has a training program but the program is not written into the EPP.	E 0036	E 036 The facility emergency preparedness plan was updated to include content related to emergency preparedness training and testing program upon hire and annually there after. During new employee orientation, essential senior health and living staff responsible for general orientation will train new staff on emergency preparedness. Additionally, training on emergency preparedness for all staff will occur at the annual employee mandatory educational fair. The EPP will be reviewed and updated at least annually by administrator/ designee.	12/31/2021

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	This finding was reviewed with the Director of Plant Operation and Administrator at the time of discovery and again at the exit conference at 3:15 p.m.			
E 0039 SS=C Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.			

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	(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.			

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	(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or			

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	(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that			

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	is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group			

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	discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and			

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	a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.			

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	(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and			

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	maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop			

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	exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year. The ICF/IID facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants. Findings include:	E 0039	A table top exercise will be completed with facility department managers to test the emergency preparedness plan by 12/31/21. Administrator/maintenance supervisor/designee are responsible to ensure full scale community based exercise and 1 additional exercise of choice is completed on an annual basis.	12/31/2021

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	Based on records review and interview with the Director of Plant Operation and Administrator on 12/1/21 between 11:15 a.m. and 12:50 p.m., the facility was able to provide documentation of its response to the COVID-19 Public Health Emergency, however, was unable to provide documentation of a second exercise of choice to test the emergency preparedness plan. Based on interview at the time of record review, the Director of Plant Operation and Administrator agreed that a second exercise of choice was not conducted. This finding was reviewed with the Director of Plant Operation and Administrator at the time of discovery and again at the exit conference at 3:15 p.m.			
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The			

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	generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration			

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	(NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review and interview, the	E 0041	E 041	12/31/2021

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	facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Director of Plant Operation on 12/1/21 between 11:15 a.m. and 12:50 p.m., no documentation of an annual fuel quality test for the diesel generator was available for review. The facility has one diesel fired generator. Based on interview at the time of records review, the fuel quality testing for the diesel fired generator could not be located and the Director of Plant Operation stated he was unaware that such a test was required. No documentation was available reflecting a fuel quality test prior to January 2020 and the beginning of the 1135 COVID waiver. This finding was reviewed with the Director of Plant Operation and Administrator at the time of discovery and again at the exit conference at 3:15 p.m.		Co-alliance was contacted by the maintenance supervisor on 12/2/21 to request an fuel quality test for the diesel generator. The fuel sample was obtained on 12/8/21. The fuel was sent off for analysis. According to company representative, fuel analysis should be completed and results returned to facility in approximately 1 week. The maintenance supervisor has added annual fuel analysis to his TELS maintenance system that will alert for annual fuel analysis. Administrator/designee will review all preventative maintenance/TELS documentation on a monthly basis to ensure compliance with LSC regulation.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/01/21	K 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	

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	Facility Number: 000373 Provider Number: 155839 AIM Number: 100288730 At this Life Safety Code survey, Summit Health and Living was found not in compliance with Requirements for Participation in Medicare, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 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 one story facility was determined to be of Type II (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 34 and had a census of 19 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except for one barn used for storage which was not sprinklered. Quality Review completed on 12/02/21		and service to the residents at Summit Health & Living. The facility requests the following plan of correction be considered its allegation of compliance.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1			

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	Based on observation and interview, the facility failed to ensure 1 of 6 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 5 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations and interview on 12/1/21 between 12:50 p.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operation, the exit door, marked as an exit near the generator and off the Therapy Kitchen, failed to open due to an improperly functioning latch. The Director of Plant Operation attempted to open the door by turning the deadbolt but was unsuccessful. The Director of Plant Operation stated that if a key was used from the outside the door would open. Based on interview at the time of the observations, the Director of Plant Operation agreed the aforementioned means of egress were not continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This finding was reviewed with the Director of Plant Operation and Administrator at the time of discovery and again at the exit conference at 3:15 p.m. 3.1-19(b)	K 0211	K 211 The maintenance supervisor determined through door assessment that extensive repair was needed on the door in order for it to function as a means of egress. The door is now marked as “not an exit”. The maintenance supervisor checks all exit doors on a weekly basis to ensure means of egress is maintained. Administrator/designee will review all preventative maintenance/TELS documentation on a monthly basis to ensure compliance with LSC regulation.	12/31/2021
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING			

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	The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation, the facility failed to meet the clear width requirement for 1 of 3 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by LSC 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in LSC 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with LSC 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with LSC	K 0232	K 232 The love Seat was previously affixed to the wall on both sides. One bracket had broken enabling one side of the loveseat to move. The love seat was affixed to the wall and floor on 12/8/21. Observation of furniture and other items projecting out into the corridor space added to the weekly maintenance rounds. Staff in-serviced by 12/31/21 to ensure staff are aware to immediately inform maintenance supervisor should hardware break to keep furniture or other projections secured to wall or floor.	12/31/2021

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	19.3.5.8 This deficient practice could affect all 19 residents, staff and visitors exiting the facilities main entrance. Findings: Based on observations and interview on 12/1/21 between 12:50 p.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operation, the main corridor near the entrance contained a leather sofa/love seat extending into the corridor approximately 37 inches. The aforementioned sofa/love seat was free standing, not affixed on both sides to the wall or floor. This finding was reviewed with the Director of Plant Operation and Administrator at the time of discovery and again at the exit conference at 3:15 p.m. 3.1-19(b)			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of			

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	hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	1. Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 5 residents, as well as staff and visitors in the corridor. Findings include: Based on observations and interview on 12/1/21 between 12:50 p.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operation, the Records Room, greater than 50 square feet, contained a number of combustible items, such as, paper, and approximately 30 cardboard boxes. The corridor door to this room was not equipped with a self-closing device. This finding was reviewed with the Director of Plant Operation and Administrator at the time of discovery and again at the exit conference at 3:15 p.m.	K 0321	And a self-closing device was installed on the storage room door on 12/6/21. All self-closing devices are checked on a weekly basis by the maintenance supervisor. This is included on his weekly preventative maintenance TELS system. Staff were in-serviced to immediately inform maintenance supervisor or administrator for improperly functioning self closing device on doors. Activity staff were in-service on 12/13/21 to only use the hot oil popcorn popper in the kitchen or outside. Administrator/designee will review all preventative maintenance/TELS documentation on a monthly basis to ensure compliance with LSC regulation.	12/31/2021

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	3.1-19(b) 2. Based on observation and interview, the facility failed to maintain protection of 1 of 1 hot oil popcorn popper in the activities storage room. This deficient practice could affect staff and up to 19 residents in the main dining room. Findings include: Based on observations and interview on 12/1/21 between 12:50 p.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operation, a hot oil popcorn popper was being stored in the activities storage room. When asked where the machine was used the Activities Director and Director of Plant Operation each stated the hot oil popcorn popper was used in the dining room. The dining room did not have a self-closing device installed and is open to the corridor. Based on interview at the time of observation, the Director of Plant Operation acknowledged the aforementioned condition and stated they would prepare the popcorn in the kitchen or outside. This finding was reviewed with the Director of Plant Operation and Administrator at the time of discovery and again at the exit conference at 3:15 p.m.			
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.			

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	Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain the ceiling construction throughout the facility. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice affects 6 residents and staff.. Findings include: Based on observations and interview on 12/1/21 between 12:50 p.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operation, the following locations had missing ceiling tiles or unsealed holes in the ceiling tiles. A) In the Medical Supply Room, a 4-inch by 12 -inch missing tile hole. B) In Utility Room #4 there were two 5-inch by 10-inch unsealed gaps along the wall on the far right side of the room. This condition could delay the activation of the installed sprinklers. This finding was reviewed with the Director of	K 0353	Fire retardant pillows were ordered on 12/16/21 and will be installed upon delivery to close the 4 x 12“ hole in the medical supply room and then ceiling tile was replaced. Gaps in utility room for will be closed with fire retardant pillows once they are delivered. Maintenance supervisor will continue through weekly, and monthly rounds to observe for openings in ceiling construction and immediately address any concerns as they arise. Administrator/designee will review all preventative maintenance/TELS documentation on a monthly basis to ensure compliance with LSC regulation.	12/31/2021

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	Plant Operation and Administrator at the time of discovery and again at the exit conference at 3:15 p.m. 3.1-19(b)			
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 1 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect 19 residents on the 100 Hall. Findings include: Based on observations and interview on 12/1/21 between 12:50 p.m. and 2:30 p.m. during a tour	K 0374	Maintenance supervisor removed the door coordinator on 12/3/21and reinstalled it. The door now closes and completely latches. Maintenance supervisor checks all smoke barrier doors on a weekly basis to ensure proper functioning. Staff in-service by 12/31/21 to immediately inform maintenance supervisor or administrator should they notice the smoke barrier door not completely closing and latching.	12/31/2021

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SUMMIT HEALTH AND LIVING	701 S MAIN ST SUMMITVILLE, IN 46070

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	of the facility with the Director of Plant Operation, the facilities one set of smoke barrier doors did not close completely and latch. Based on interview during the time of observations, the Director of Plant Operation acknowledged these smoke barrier doors did not close completely and latch stating that they are constantly having to adjust the coordinator on the door. This finding was reviewed with the Director of Plant Operation and Administrator at the time of discovery and again at the exit conference at 3:15 p.m. 3.1-19(b)		Administrator/designee will review all preventative maintenance/TELS documentation on a monthly basis to ensure compliance with LSC regulation.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure 1 of over 10 wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location.	K 0511	The GFIC plug was installed for the commercial grade washing machine in the laundry area by the maintenance supervisor on 12/3/21. The operation of the receptacle was tested and the plug was found to be operating as designed. Maintenance supervisor toured building to ensure all other plugs were GFIC protected as required.	12/31/2021

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	(B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B) (1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations			

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	(7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect 3 staff while in the laundry area. Findings include: Based on observations and interview on 12/1/21 between 12:50 p.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operation, the commercial grade washing machine in the laundry area was less than 12 inches from a receptacle which was not GFCI protected. A test of the receptacle verified the receptacle was not on a GFCI circuit. This finding was reviewed with the Director of Plant Operation and Administrator at the time of discovery and again at the exit conference at 3:15 p.m. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of over 10 electrical junction boxes above the ceiling was protected from damage. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals,			

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	Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect 6 residents in room 100 hall. Findings include: Based on observations and interview on 12/1/21 between 12:50 p.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operation, above the drop in ceiling near the smoke wall doors, a junction box was not installed properly allowing exposed wires to protrude through the side of the box. Based on interview at the time of observation, the Director of Plant Operation stated there appeared to be a stripped green wire protruding from the box. This finding was reviewed with the Director of Plant Operation and Administrator at the time of discovery and again at the exit conference at 3:15 p.m. 3.1-19(b)			
K 0761 SS=E Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of at least 1 fire door assembly was completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying	K 0761	Annual fire door inspection completed by the maintenance supervisor on 12/8/21. The door to the O2 room has a 90 minute door assembly. The door is intact and operational as should be. Annual inspection added to TELS preventative maintenance system for annual inspection. Administrator/designee will review all preventative maintenance/TELS documentation on a monthly basis	12/31/2021

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	hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and		to ensure compliance with LSC regulation.	

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	integrity. This deficient practice could affect 15 residents. Findings include: Based on records review and interview with the Director of Plant Operation and Administrator on 12/1/21 between 11:15 a.m. and 12:50 p.m., no documentation of an annual inspection for the fire door assembly at the Oxygen Transfilling room was available for review. Based on observation during the tour the Oxygen Transfilling room has one 90-minute fire door assembly. Based on interview at the time of records review and observation, the Director of Plant Operation stated the annual fire door inspection was not completed within the last year and was previously unaware a fire door inspection was needed on the Transfilling Room door. No documentation was available reflecting a door inspection prior to January 2020 and the beginning of the 1135 COVID waiver. This finding was reviewed with the Director of Plant Operation and Administrator at the time of discovery and again at the exit conference at 3:15 p.m. 3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance			

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	and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 facility's diesel-powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality	K 0918	Co-alliance was contacted by the maintenance supervisor on 12/2/21 to request an fuel quality test for the diesel generator. The fuel sample was obtained on 12/8/21. The fuel was sent off for analysis. According to company representative, fuel analysis should be completed and results returned to facility in approximately 1 week. The maintenance supervisor has	12/31/2021

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	test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents. Findings include: Based on records review and interview with the Director of Plant Operation on 12/1/21 between 11:15 a.m. and 12:50 p.m., no documentation of an annual fuel quality test for the diesel generator was available for review. The facility has one diesel fired generator. Based on interview at the time of records review, the fuel quality testing for the diesel fired generator could not be located and the Director of Plant Operation stated he was unaware that such a test was required. No documentation was available reflecting a fuel quality test prior to January 2020 and the beginning of the 1135 COVID waiver. This finding was reviewed with the Director of Plant Operation and Administrator at the time of discovery and again at the exit conference at 3:15 p.m. 3.1-19(b)		added annual fuel analysis to his TELS maintenance system that will alert for annual fuel analysis. Administrator/designee will review all preventative maintenance/TELS documentation on a monthly basis to ensure compliance with LSC regulation.	