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

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	01/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 12/01/21 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/20/22 Facility Number: 000373 Provider Number: 155839 AIM Number: 100288730 At this PSR survey, Summit Health and Living was found 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 PSR survey, the census was 24. Quality Review completed on 01/24/22	E 0000		
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 12/01/21 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/20/22 Facility Number: 000373 Provider Number: 155839 AIM Number: 100288730	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 and service to the residents at Summit Health & Living. The facility requests the following plan of correction be considered its allegation of compliance.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	At this PSR survey, Summit Health and Living was found in substantial 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 24 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 01/24/22			
K 0100 SS=B Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.			
	Based on observation and interview, the facility failed to maintain latching hardware on 1 of 1 exterior doors per Section 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code,	K 0100	The lock on the exit door off the therapy kitchen leading to the side facility parking lot was replaced on 2/8/22. Maintenance supervisor checks	02/08/2022

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	shall be either maintained or removed. 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 01/20/22 between 11:40 a.m. and 12:30 p.m. during a tour of the facility with the Administrator, the exit door, now marked as "not an exit" near the generator and off the Therapy Kitchen, failed to open due to an improperly functioning latch. The Administrator attempted to open the door by turning the deadbolt but was unsuccessful. The Director of Plant Operation stated at the exit conference that a lockset had been ordered and they were in touch with a locksmith. If necessary, they would replace the entire 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 12:30 p.m. 3.1-19(b)		this lock at least weekly to ensure the lock is turning smoothly and can be unlocked. This door while is leads to a side parking lot is not visible or used routinely by staff of visitors.	