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	11/03/2022

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: October 31, November 1, 2, and 3, 2022. Facility number: 000373 Provider number: 155839 AIM number: 100288730 Census Bed Type: SNF/NF: 27 Total: 27 Census Payor Type: Medicare: 5 Medicaid: 19 Other: 3 Total: 27 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 4, 2022	F 0000	Submission of this plan of correction shall not constitute or be construed as an admission by Summit Health and Living that the allegations contained in this survey report are accurate or reflect accurately the provision of care and services to the residents at Summit Health and Living. The facility requests the following plan of correction be considered its allegation of compliance. We respectfully request paper compliance due to the low scope and severity of these two tags.	
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2			

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

Pamela Sipes | Administrator | 11/23/2022

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	hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to ensure an allegation of abuse had been reported timely for 2 of 2 residents reviewed (Resident 15 and Resident 8). Findings include: 1. During an interview, on 11/1/22 at 1:37 p.m., Resident 15 indicated he had come from a family of 10 brothers and he wasn't bothered by the other residents. During an observation, on 11/1/22 at 3:41 p.m., he was sitting in a wheel-chair in the library with a staff member and two other male residents. His clinical record was reviewed on 11/2/22 at 9:55 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance and	F 0609	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Neither resident #15 nor #8 remember the incident. In the event that we have another resident to resident disagreement or threat the Administrator will report to IDOH within the required time frame of 2 hrs. However, according to the regulations abuse is defined as "the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish." This was not	11/18/2022

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	delusional disorders. A 9/29/22 admission MDS (Minimum Data Set) assessment indicated he had moderate cognitive impairment. A current care plan, initiated 9/23/22, indicated he had the potential to demonstrate verbally abusive behaviors related to dementia, poor impulse control, adjustment disorder and trouble adjusting to the facility. The goal, with a target date of 12/21/22, indicated he demonstrated effective coping skills through the review date. Interventions included assessed resident's understanding of a situation and allowed time for him to express himself and his feelings about the situation. A progress note, dated 10/28/22 at 9:00 a.m., indicated Resident 15 was in the library yelling for help, he told a staff member another resident (Resident 8) told him he was going to blow his head off. The resident was removed from the library, assisted to the nurses station and was able to repeat what had been said to him. 2. During an interview, on 10/31/22 at 10:58 a.m., Resident 8 indicated he attended some activities and had been treated well. During an observation, on 11/1/22 at 3:40 p.m., he was sitting in a wheel-chair in his room talking with his wife. Resident 8's clinical record was reviewed on 111/1/22 at 2:33 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, PTSD (Post-Traumatic Stress Disorder), homicidal ideation and violent behavior.		reported because there was no sign of physical harm, pain or mental anguish. Both residents had forgotten the incident within 5 minutes and # 15 was not showing signs of being upset. I would like for this tag to be deleted for that reason. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents could be affected. The Administrator or her designee will report all resident to resident threats with harm within the time frame of 2 hrs. The Administrator has been re-educated regarding reporting requirements. All employees have been re-educated regarding the need to report any and all incidents immediately to the Administrator. WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: An Audit tool has been created to assist in assuring that all resident to resident situations are evaluated and reported per	

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	An 8/8/22 quarterly MDS assessment indicated he had moderate cognitive impairment. A current care plan, initiated 8/4/22, indicated he was seen by psych services for PTSD in Vietnam, certain things triggered him to have homicidal ideation. The goal, with a target date of 1/10/23, indicated he would continue to speak with psych services for the benefit of his mental health through the review. Interventions included, allowed to discuss his feelings, medication per physician recommendation and provided reassurance when he felt down. A progress note, dated 10/28/22 at 9:10 a.m., indicated another resident (Resident 15) had alleged he was going to blow that resident's head off. He had shook his head no, and indicated he may have implied it or said something about a pistol, the other resident bumped into him with his wheel-chair and it made him mad. Resident 8 was reminded that it was not appropriate to have said that and he needed to ask for staff assist with his needs. Residents had been separated and 15 minute safety checks had been started. During an interview, on 11/1/22 at 12:45 p.m., the Administrator indicated she did not report the allegation and didn't feel it needed to be reported. Review of a current facility policy, titled "ABUSE, NEGLECT, AND EXPLOITATION," with a revised date of 10/2022 and provided by the Director of Nursing on 11/3/22 at 10:23 a.m., indicated "...1. The Abuse Coordinator in the facility is the Director of Nursing, Administrator, or facility appointed designee. Report allegations or suspected abuse, neglect, or exploitation immediately to: Administrator, Other Officials in		guidelines. This tool will be utilized during morning clinical meetings to assure that nothing is missed. The Administrator will monitor this tool on a daily (5 days week) basis by going over all incidents that occurred. The IDT team will double check to assure all reportables are completed. A Performance Improvement Plan (PIP) has been initiated to assure compliance. All resident to resident threats with harm will be reported to IDOH within the 2 hr timeline by the Administrator or the designee. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR; IE, WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: A performance improvement plan (PIP) has been completed. This plan states that all resident to resident interactions showing a harm outcome will be evaluated for the need to report according to the guidelines from IDOH. The Administrator and the QAPI committee will monitor the results of the audit tool by checking the 24 hr report on Point Click Care at a minimum 5 days a week. The monitoring will be discussed during the morning clinical meetings that are held daily. The PIP will be discussed during the	

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	accordance with State Law, State Survey and Certification agency through established procedures...." 3.1-28(c)		QAPI monthly meetings to assure compliance. This will continue for at least six months. Monitoring will continue for at least 6 months. Once 100% compliance has been established for at least six months, the committee will determine the need to continue.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to accurately code medications on the Minimum Data Set (MDS) assessment for 2 of 16 sampled residents (Residents 11 and 24). Findings include: 1. Resident 11's clinical record was reviewed on 11/3/22 at 9:43 a.m. Diagnoses, included but were not limited to, major depressive disorder. A 10/3/22 quarterly MDS assessment indicated the resident received an antipsychotic medication. A gradual does reduction (GDR) was attempted on 6/28/22. Physician's orders during the MDS assessment period lacked an order for an antipsychotic medication. During an interview, on 11/3/22 at 2:40 p.m., the MDS coordinator indicated the resident did not take antipsychotic medications. She indicated the MDS was coded incorrectly; the resident received an antidepressant medication and not an antipsychotic medication. The GDR date was for	F 0641	WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? Resident 11's MDS was modified on 11/3/22 to reflect her not being on an antipsychotic medication. Resident # 24's MDS was modified on 10/26/22 to reflect her use of an antipsychotic medication. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN? Nursing management completed a 100% audit of the psychoactive medication "Section N" of all residents' most recently completed MDS and modifications were completed on 11/15/22. All	11/18/2022

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	the reduction in the antidepressant medication. 2. Resident 24's clinical record was reviewed on 11/2/22 at 12:58 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, psychotic disorder with delusions due to known physiological condition, dementia with behavioral disturbance, major depressive disorder and anxiety disorder. A 10/24/22 quarterly MDS assessment indicated the resident did not receive antipsychotic medications. Current physician's medication orders included, quetiapine fumarate (antipsychotic) 100 mg daily ordered on 9/28/22. During an interview, on 11/3/22 at 2:35 p.m., the MDS Coordinator indicated the coding in the MDS was an input error. The resident received an antipsychotic medication during the MDS assessment period. During an interview, on 11/3/22 at 3:32 p.m., the MDS Coordinator indicated the Resident Assessment Instrument (RAI) manual was used as the facility's policy for the MDS assessments. The current RAI manual indicated, " ...Review the resident's medication administration records to determine if the resident received an antipsychotic medication since admission/entry or reentry or the prior OBRA assessment, whichever is more recent. Code 1, yes: if antipsychotics were received on a routine basis only ..."		incorrect coding has been corrected. WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT OCCUR? MDS coordinator reeducated 11/15/22 on psychoactive medication and coding of antipsychotic medications on MDS section N. RN signing off MDS will review 100 % of Section N for accuracy prior to each MDS submission. HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E, WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE? RN signing off MDS will review 100 % of Section N for accuracy prior to each MDS submission. A tracking tool will be completed with documentation of the auditing on a weekly basis. MDS Section N accuracy tracking tool information will be presented at monthly QAPI meetings. The QAPI committee will check the audit tool to assure compliance during the monthly meetings. This will continue to be tracked until we are 100% compliant with coding for at least six months. At that	

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			time the QAPI committee will make the decision to continue the monitoring or justify stopping it.	