01/17/2023

	PEPARTMENT OF HEALTH AND HUMAN SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION						
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155839	(X2) MUI A. BUII B. WIN	DING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/22/2022	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 701 S MAIN ST SUMMITVILLE, IN 46070				
(X4) ID PREFIX TAG E 0000	(EACH DEFICIE	T STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OF LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
Bldg	conducted by the I accordance with 4.2 Survey Date: 12/2 Facility Number: (Provider Number: AIM Number: 100 At this Emergency Health and Living with Emergency P Medicare and Medicare and Suppliers, 42 (capacity of 34 and of this survey.	22/2022 000373 155839	E 000	00	Submission of this plan of correction shall not constitute be construed as an admission Summit Health and Living the allegations contained in this survey report are accurate or reflect accurately the provisio care and services to the residust Summit Health and Living. facility requests the following of correction be considered it allegation of compliance.	n by at the n of lents The plan	
E 0034 SS=F Bldg	441.184(c)(7), 484 483.73(c)(7), 484 485.68(c)(5), 485 491.12(c)(5), 494 Information on O §403.748(c)(7), § §441.184(c)(7), § §483.73(c)(7), §4 (6), §485.68(c)(5						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated

§491.12(c)(5), §494.62(c)(7).

TITLE (X6) DATE

Pamela Sipes Administrator 01/11/2023

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.

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	LDING		COMPL	COMPLETED	
		155839	B. WING	G	_	12/22	/2022	
NAME OF I	DDOVIDED OD STIDDI IEI)	<u>'</u>	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF			701 S M	IAIN ST			
SUMMIT	HEALTH AND LIVI	NG		SUMMI	TVILLE, IN 46070			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE	
		ears [annually for LTC						
	_	mmunication plan must						
	include all of the f	ollowing:						
	(7) [(5) or (6)] A m	neans of providing						
	. , , . ,	the [facility's] occupancy,						
	needs, and its abi	lity to provide assistance,						
	to the authority ha	ving jurisdiction, the						
	Incident Comman	d Center, or designee.						
	*IFor ASCs at 416	6.54(c)]: (7) A means of						
	_	tion about the ASC's needs,						
		rovide assistance, to the						
		urisdiction, the Incident						
	Command Center							
		spice at §418.113(c):] (7) A						
	· ·	g information about the						
		it occupancy, needs, and						
		le assistance, to the						
		urisdiction, the Incident						
	Command Center	view and interview, the facility	E 002	. 1	WHAT CORRECTIVE ACTIO	NI	01/09/2022	
		emergency preparedness	E 003	· +	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FROM		01/08/2023	
		n includes a means of			THOSE RESIDENTS FOUND			
		ion about the LTC facility's			HAVE BEEN AFFECTED BY			
		and its ability to provide			DEFICIENT PRACTICE:			
		athority having jurisdiction or			No residents were affected. T	he		
		and Center, or designee in			Evacuation Policy/Procedure			
		CFR 483.73(c)(7). This			updated to include the means			
		ould affect all occupants.			use to provide information abo			
					our occupancy, needs and ou			
	Findings include:				ability to provide assistance to	the		
					authority having jurisdiction or			
		the facility's Emergency			Incident Command Center, or			
	Preparedness Plan (EPP) with the Administrator and Maintenance Supervisor on 12/22/22 at 11:30			designee. A copy is Attachme	ent			
				"A."				
		EPP communication plan did						
		s of providing information			HOW OTHER RESIDENTS			
	about the LTC facil	lity's occupancy, needs, and its	1		HAVING THE POTENTIAL TO) BE	1	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155839		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/22/2022	
	PROVIDER OR SUPPLIER HEALTH AND LIVI		701 S	ADDRESS, CITY, STATE, ZIP COD MAIN ST MITVILLE, IN 46070	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF ability to provide as	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION sistance to the authority or the Incident Command	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) AFFECTED BY THE SAME DEFICIENT PRACTICE WILL	DATE
	Center, or designee time of records revi the Administrator lo could not find a pla providing informati	Based on interview at the ew and during exit conference, boked through the EPP and in that addressed a means of on about the LTC facility's and its ability to provide		IDENTIFIED AND WHAT CORRECTIVE ACTION WIL TAKEN: All residents have the potential to be affected. The policy/procedure was update is Attachment "A."	L BE he
				WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL MADE TO ENSURE THAT TO DEFICIENT PRACTICE DOE NOT RECUR: All nursing staff was educate regarding this update on 12/28/22. See Attachment "Opgs. All nurses will be educated as they hire on to assure compliance.	AT . BE HE ES d
				HOW THE CORRECTIVE AC WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUMHAT QUALITY ASSURANCE PROGRAM WILL BE PUT IN PLACE: The Maintenance Director wiconduct a table top exercise nursing on a quarterly basis a bring the results to the quarter QAPI meetings for evaluation This will continue for a minimisix months.	JR; CE ITO II for and erly n.
E 0039 SS=C	, , , ,	6.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2),			

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NDVA21

Facility ID: 000373

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155839		UILDING	NSTRUCTION	(X3) DATE COMPI 12/22	LETED		
	PROVIDER OR SUPPLIER HEALTH AND LIVI		STREET ADDRESS, CITY, STATE, ZIP COD 701 S MAIN ST SUMMITVILLE, IN 46070						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE	(X5) COMPLETION DATE		
Bldg	483.73(d)(2), 484. 485.68(d)(2), 485. 486.360(d)(2), 497. EP Testing Require \$416.54(d)(2), \$47. \$460.84(d)(2), \$47. \$483.475(d)(2), \$47. \$485.625(d)(2), \$47. (2), \$491.12(d)(2), \$47. (2), \$491.12, and ESF. (2) Testing. The [freexercises to test the street of the stre	102(d)(2), 485.625(d)(2), 727(d)(2), 485.920(d)(2), 1.12(d)(2), 494.62(d)(2) rements 18.113(d)(2), §441.184(d)(2), 32.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d), ,§494.62(d)(2). 6.54, CORFs at §485.68, ons" under §485.727, 20, RHCs/FQHCs at RD Facilities at §494.62]: acility] must conduct he emergency plan fility] must do all of the full-scale exercise that is every 2 years; or nunity-based exercise is nduct a facility-based every 2 years; or lity] experiences an actual ade emergency plan, the [facility] gaging in its next requires mergency plan, the [facility] gaging in its next required or individual, facility-based exercise at least posite the year the full-scale cise under paragraph (d)(2) is conducted, that may limited to the following: scale exercise that is or individual, facility-based							

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NDVA21 Facility ID: 000373

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155839	JILDING	NSTRUCTION	(X3) DATE : COMPL 12/22/	ETED
	PROVIDER OR SUPPLIER HEALTH AND LIVI		701 S M	ADDRESS, CITY, STATE, ZIP COD MAIN ST TVILLE, IN 46070		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	led by a facilitator discussion using a clinically-relevant set of problem sta messages, or prep to challenge an er (iii) Analyze the [famaintain documer exercises, and em the [facility's] eme *[For Hospices at (2) Testing for ho the patient's home conduct exercises plan at least annuthe following: (i) Participate in a community based (A) When a community based (A) When a community based functional exercises plan at least annuthe following: (ii) Participate in a community based functional exercises of the emergency exempt from engascale community-facility-based functionset of the emerging in Conduct an acceptance of the emerging of this section is conclude, but is not	and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. acility's] response to and atation of all drills, tabletop mergency events, and revise rgency plan, as needed. 418.113(d):] spices that provide care in e. The hospice must to test the emergency ally. The hospice must do full-scale exercise that is every 2 years; or unity based exercise is not ct an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is ging in its next required full pased exercise or individual tional exercise following the gency event. Iditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: scale exercise that is or a facility based e; or				

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	OF CORRECTION	IDENTIFICATION NUMBER 155839	r í	UILDING		COMPL 12/22	ETED
	PROVIDER OR SUPPLIER HEALTH AND LIVI			701 S M	ADDRESS, CITY, STATE, ZIP COD MAIN ST TVILLE, IN 46070		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
	(C) A tabletop excled by a facilitator discussion using a clinically-relevant set of problem sta messages, or prepto challenge an er (3) Testing for hos care directly. The exercises to test the per year. The hos	ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed energency plan. Spices that provide inpatient hospice must conduct the emergency plan twice spice must do the following:					
	(i) Participate in a that is community. (A) When a comm accessible, condu facility-based function (B) If the hospice man-made emerg of the emergency exempt from engatull-scale communifunctional exercise emergency event.	n annual full-scale exercise based; or unity-based exercise is not ct an annual individual tional exercise; or experiences a natural or ency that requires activation plan, the hospice is ging in its next required ity based or facility-based e following the onset of the					
	that may include, following: (A) A second full-community-based functional exercise (B) A mock disast (C) A tabletop exercise facilitator that inclusing a narrated, emergency scena statements, direct questions designed emergency plan. (iii) Analyze the h	e; or ter drill; or ercise or workshop led by a udes a group discussion clinically-relevant rio, and a set of problem ed messages, or prepared					

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Event ID:

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		(X2) M	ULTIPLE CO	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		155839	B. W	ING		12/22	/2022
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			MAIN ST		
SUMMIT	HEALTH AND LIVI	NG			TVILLE, IN 46070		
	Г		1	<u> </u>			T .
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
	exercises, and emergency events and revise the hospice's emergency plan, as needed.						
	the nospice's eme	ergency plan, as needed.					
	*IFor PRFTs at 8/	141.184(d), Hospitals at					
	§482.15(d), CAHs						
	. , ,	PRTF, Hospital, CAH] must					
		s to test the emergency					
		ar. The [PRTF, Hospital,					
	CAH] must do the						
	_	an annual full-scale exercise					
	that is community						
	1	nunity-based exercise is not					
	1 ' '	ıct an annual individual,					
		ctional exercise; or					
	(B) If the [PRTF, I	Hospital, CAH] experiences					
	an actual natural	or man-made emergency					
	that requires activ	ation of the emergency					
	plan, the [facility] i	is exempt from engaging in					
	its next required for	ull-scale community based					
	or individual, facili	ty-based functional exercise					
	1	et of the emergency event.					
	· '	an [additional] annual					
		at may include, but is not					
	limited to the follo						
	1 ' '	scale exercise that is					
	community-based						
	1	ctional exercise; or					
	, ,	ock disaster drill; or					
	. , ,	exercise or workshop that					
	1	or and includes a group					
	discussion, using						
		emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er						
		he [facility's] response to					
		umentation of all drills,					
		s, and emergency events					
	and revise the [fac	cility's] emergency plan, as					

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	OF CORRECTION	IDENTIFICATION NUMBER 155839	A. B	A. BUILDING B. WING			eted 2022
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
SUMMIT	HEALTH AND LIVI	NG			TVILLE, IN 46070		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	needed.	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE!		DATE
	needed.						
	*[For PACE at §46	60.84(d):]					
	-	ACE organization must					
	conduct exercises	to test the emergency					
	plan at least annu	ally. The PACE					
	organization must	do the following:					
		n annual full-scale exercise					
	that is community-						
		nunity-based exercise is not					
		ct an annual individual,					
	facility-based fund						
	, ,	operiences an actual natural ergency that requires					
		mergency plan, the PACE					
		gaging in its next required					
		nity based or individual,					
		tional exercise following the					
	onset of the emer	_					
		n additional exercise every					
	, ,	he year the full-scale or					
	functional exercise	e under paragraph (d)(2)(i)					
	of this section is c	onducted that may include,					
	but is not limited to	•					
	` '	scale exercise that is					
		or individual, a facility					
	based functional e						
	(B) A mock disast	ter drill; or ercise or workshop that is					
	. ,	and includes a group					
	discussion, using	~ .					
	-	emergency scenario, and a					
	set of problem sta						
	•	pared questions designed					
	to challenge an er	· · · · · · · · · · · · · · · · · · ·					
	-	PACE's response to and					
	maintain documer	ntation of all drills, tabletop					
		nergency events and revise					
	the PACE's emerg	gency plan, as needed.					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155839		ILDING	NSTRUCTION	(X3) DATE : COMPL 12/22/	ETED
	PROVIDER OR SUPPLIER		•	701 S N	ADDRESS, CITY, STATE, ZIP COD MAIN ST TVILLE, IN 46070		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	to test the emerge year, including un the emergency pr ICF/IID] must do to to Participate in a that is community (A) When a commaccessible, conduct facility-based function (B) If the [LTC fact actual natural or requires activation LTC facility is exerequired a full-scalindividual, facility-following the onse (ii) Conduct an actual may include, following: (A) A second full-community-based based functional of the community-based functional of the community-based functional of the community-based functional of the community-based based functional of the community-based functional of the community-based based functional of the community-based functional of the community-based functional of the community-based based functional of the community-based functional of the community-based functional of the community-based functional of the comm	ency plan at least twice per announced staff drills using ocedures. The [LTC facility, he following: an annual full-scale exercise based; or nunity-based exercise is not act an annual individual, etional exercise. ility] facility experiences an annual emergency plan, the mpt from engaging its next alle community-based or based functional exercise at of the emergency event. In othe emergency event. In other emergency event. It is not limited to the exercise; or the drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a attements, directed pared questions designed mergency plan. LTC facility] facility's maintain documentation of exercises, and emergency et the [LTC facility] facility's as needed.					

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	ENT OF DEFICIENCIES IN OF CORRECTION	IDENTIFICATION NUMBER 155839	A. BUILDI B. WING	ING	COM	PLETED 22/2022
	F PROVIDER OR SUPPLIEF		70	REET ADDRESS, CITY, STATE, 2 D1 S MAIN ST UMMITVILLE, IN 46070	ZIP COD	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R I SC IDENTIFYING INFORMATION	ID PRE	FIX PROVIDER'S PLAN O (EACH CORRECTIVE ACT CROSS-REFERENCED TO	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION
TAG	exercises to test to twice per year. The following: (i) Participate in a strate is community. (A) When a community (A) When a community (B) If the ICF/IID enatural or man-man activation of the endit is exempt from endit facility-based functions on the endit on the endit of the emer (ii) Conduct an addit that may include, following: (A) A second full-community-based facility-based functions (B) A mock disast (C) A tabletop exelled by a facilitator discussion, using clinically-relevant set of problem state of p	nunity-based exercise is not lect an annual individual, etional exercise; or. experiences an actual ade emergency that requires mergency plan, the ICF/IID gaging in its next required nity-based or individual, etional exercise following the gency event. ditional annual exercise but is not limited to the scale exercise that is or an individual, etional exercise; or er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. CF/IID's response to and nation of all drills, tabletop nergency events, and revise regency plan, as needed.	TA			DATE

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155839	A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/22/2022	
	PROVIDER OR SUPPLIEI			701 S N	ADDRESS, CITY, STATE, ZIP COD MAIN ST TVILLE, IN 46070	-		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	(X5) COMPLETION	
TAG	community-based	R LSC IDENTIFYING INFORMATION 1: or		TAG	DEFICIENCY)		DATE	
	(A) When a cossible,	community-based exercise conduct an annual						
	every 2 years; or.							
	natural or man-ma	A experiences an actual ade emergency that requires						
		mergency plan, the HHA is aging in its next required						
		nity-based or individual, ctional exercise following the						
	onset of the emer	gency event.						
	` '	Iditional exercise every 2 ne year the full-scale or						
		e under paragraph (d)(2)(i)						
	of this section is o							
		limited to the following:						
		full-scale exercise that is						
	community-based	l or an individual,						
	facility-based fund	ctional exercise; or						
	, ,	isaster drill; or						
		p exercise or workshop that						
	•	tor and includes a group						
	discussion, using							
		emergency scenario, and a atements, directed						
	1	pared questions designed						
	to challenge an e	-						
		HA's response to and						
		ntation of all drills, tabletop						
	exercises, and en	nergency events, and revise						
	the HHA's emerge	ency plan, as needed.						
	*[For OPOs at §4							
		e OPO must conduct						
		he emergency plan. The						
	OPO must do the	•						
		er-based, tabletop exercise ast annually. A tabletop						
	1	ast annually. A tabletop a facilitator and includes a						

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155839	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/22/2022			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 701 S MAIN ST SUMMITVILLE, IN 46070					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE			
	relevant emergen problem statemen problem statemen prepared question emergency plan. I actual natural or nequires activation OPO is exempt for required testing exof the emergency (ii) Analyze the Ol maintain document exercises, and emithe [RNHCI's and needed. *[RNCHIs at §403 (d)(2) Testing. The exercises to test to the total composition of the emergency of the emergency of the emergency (ii) Analyze the total composition of the emergency of t	PO's response to and natation of all tabletop hergency events, and revise OPO's] emergency plan, as a.748]: Be RNHCI must conduct the emergency plan. The her following: Ber-based, tabletop exercise as a led by a facilitator, using a perelevant emergency plan. Are relevant emergency plan. All tabletop exercise as a led by a facilitator, using a perelevant emergency plan. All tabletop hergency events, and revise regency plan, as needed. Proview and interview, the facility dereises to test the emergency per year, including drills using the emergency of facility must do the annual full-scale exercise that	E 0039	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED IN THOSE RESIDENTS FOUND HAVE BEEN AFFECTED BY DEFICIENT PRACTICE: No residents were affected.	FOR D TO			

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPI	LETED
		155839	B. W	ING		12/22	/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	R			MAIN ST		
SUMMIT	THEALTH AND LIV	ING			ITVILLE, IN 46070		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	accessible, conduct	t an annual individual,			HOW OTHER RESIDENTS		
	facility-based funct	tional exercise.			HAVING THE POTENTIAL TO) BE	
	b. If the LTC facili	ty experiences an actual natural			AFFECTED BY THE SAME		
	or man-made emer	gency that requires activation			DEFICIENT PRACTICE WILL	BE	
	of the emergency p	olan, the LTC facility is exempt			IDENTIFIED AND WHAT		
	from engaging its r	next required full-scale in a			CORRECTIVE ACTION WILL	BE	
	community-based	or individual, facility-based			TAKEN:		
	full-scale functiona	al exercise for 1 year following			All residents could be affected		
	the onset of the act	ual event.			The Maintenance Supervisor I	nas	
	(ii) Conduct an add	litional exercise that may			been re-educated regarding th		
include, but is not limited to the following: a. A second full-scale exercise that is				need to follow up after any dril			
				do an after action report that			
	community-based or an individual, facility-based				includes analyzing how the fac	cility	
	functional exercise				responded, what was good an	-	
	b. A mock disaster	drill; or			what needs to be improved.		
		ise or workshop that is led by a			Attachment "B." That after ac	tion	
	_	ides a group discussion, using			report will be included in the p		
		ly-relevant emergency scenario,			of the drill and will include the		
		n statements, directed			following: what was supposed	d to	
	_	red questions designed to			happen, what occurred, what		
	challenge an emerg	-			well, what the facility can do		
		ΓC facility's response to and			differently or improve upon an	d a	
		tation of all drills, tabletop			plan with timelines for	u u	
		rgency events, and revise the			incorporating necessary		
		rgency plan, as needed in			improvements. (attachment "A	Δ")	
	-	2 CFR 483.73(d)(2). This			improvements. (attachment 7)	<i>u ()</i>	
		ould affect all occupants.					
	deficient practice c	ould affect all occupants.			WHAT MEASURES WILL BE		
	Findings include:				PUT INTO PLACE AND WHA	т	
	i manigs merade.				SYSTEMIC CHANGES WILL		
	Based on records re	eview with the Administrator			MADE TO ENSURE THAT TH		
		ce Supervisor on 12/22/22 at			DEFICIENT PRACTICE DOES		
	11:40 a.m., docume	•				ی	
		exercise conducted on 12/08/22			NOT RECUR:	2000	
	1	exercise conducted on 12/08/22 exercise conducted on 11/03/22			After every event the Maintena	ance	
					Director will get with the	_	
	_	Both exercises did not show if			Administrator to sign off on the		
		nse was analyzed to ensure the			drill and to assure that these a	itter	
	EPP policies were	effective. Based on interview at	1		action items are included.		1

the time of records review and at the exit conference, the Administrator stated, no

NDVA21

HOW THE CORRECTIVE ACTION

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	of correction (X1) provider/supplier/clia (IDENTIFICATION NUMBER (155839)	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/22/2022
	PROVIDER OR SUPPLIER HEALTH AND LIVING	701 S N	ADDRESS, CITY, STATE, ZIP COD MAIN ST ITVILLE, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	documentation for analyzing the LTC facility's response was completed.		WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECU WHAT QUALITY ASSURANC PROGRAM WILL BE PUT IN PLACE: A Performance Improvement Plan has been completed for our quarterly Quinceting. The results of the drivill be discussed during the quarterly QAPI meetings to as compliance. These results with continue for a minimum of six months and at least until 100% compliance is achieved after edrill.	EE TO API rills ssure II
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: 12/22/2022 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/Medicaid, 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.	K 0000	Submission of this plan of correction shall not constitute be construed as an admission Summit Health and Living that allegations contained in this survey report are accurate or reflect accurately the provision care and services to the residuat Summit Health and Living. facility requests the following of correction be considered its allegation of compliance.	t the n of ents The plan

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155839	B. WING		12/22/2022
			STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	ROVIDER OR SUPPLIER			MAIN ST	
SUMMIT	HEALTH AND LIVI	NG	SUMN	MITVILLE, IN 46070	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE
	_	ity was determined to be of ruction and was fully			
		cility has a fire alarm system			
	_	on in the corridors, areas open			
		hard wired smoke detectors in			
		The facility has a capacity of			
		s of 28 at the time of this			
	survey.	of 20 at the time of this			
		residents have customary			
	_	ered. All areas providing			
facility services were sprinklered.		re sprinklered.			
	Quality Review con	npleted on 12/28/22			
K 0211	NFPA 101				
SS=E	Means of Egress -	- General			
Bldg. 01	Means of Egress -	- General			
	Aisles, passagewa	ays, corridors, exit			
	discharges, exit lo	cations, and accesses are			
	in accordance with	n Chapter 7, and the means			
	_	uously maintained free of			
	all obstructions to				
		s modified by 18/19.2.2			
	through 18/19.2.1				
	18.2.1, 19.2.1, 7.1				
		on and interview, the facility	K 0211	WHAT CORRECTIVE ACTIO	01/00/2025
		f 4 corridor means of egresses		WILL BE ACCOMPLISHED F	
	were continuously r			THOSE RESIDENTS FOUND	
	residents and 5 staff	deficient practice affects 5		HAVE BEEN AFFECTED BY	THE
	residents and 5 stari			DEFICIENT PRACTICE: No residents were affected. 1	-ho
	Findings include:			Housekeeping Supervisor ren	
	i manigs metade.			all of the items that were in the	
	Based on observation	on during an initial tour of the		hallway.	
	facility with the Ma	intenance Supervisor on			
	12/22/22 at 10:45 a.	m and at 12:10 pm during the			
	facility tour in the e	xit egress by utility room 4,			
		rt measuring 2 feet wide by 4		HOW OTHER RESIDENTS	
	feet long against the	e wall obstructing travel to the		HAVING THE POTENTIAL TO	O BE

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155839	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 12/22/2022
	PROVIDER OR SUPPLIER HEALTH AND LIVI		701 S	ADDRESS, CITY, STATE, ZIP COD MAIN ST IITVILLE, IN 46070	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	exit . Just around the treatment room in the were 16 boxes of such the exit egress. Base of observations, the stated that these iter removed. These findings were Administrator and the exit conference. 3.1-19(b)	e corner by the private ne hall going to therapy there upplies stacked that obstructed ned on an interview at the time Maintenance Supervisor ns in the corridor would be		AFFECTED BY THE SAME DEFICIENT PRACTICE WILL IDENTIFIED AND WHAT CORRECTIVE ACTION WILL TAKEN: All residents could be affected the Housekeeping Supervisor Maintenance Director will be responsible to remove all book left in the hallway as soon as are delivered. WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL MADE TO ENSURE THAT TO DEFICIENT PRACTICE DOE NOT RECUR: The Maintenance Director with daily walk throughs to assure compliance. Attachment "C." HOW THE CORRECTIVE ACT WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECURENT WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT IN PLACE: The results of the walk through will be discussed during the quarterly QAPI meetings. The continue for a minimum of six months and/or when 100% compliance has been achieved at least six months.	L BE L BE d. or and des they EAT BE HE ES II do CTION JR; CE ITO ghs iis will c
K 0321 SS=F Bldg. 01	NFPA 101 Hazardous Areas Hazardous Areas				

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	of correction (X1) provider/supplier/clia (IDENTIFICATION NUMBER (155839)	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 12/22/2022
	PROVIDER OR SUPPLIER HEALTH AND LIVING	701 S N	ADDRESS, CITY, STATE, ZIP COD MAIN ST TVILLE, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	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 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) Based on observation and interview, the facility failed to ensure the corridor doors to multiple areas which are a considered to be hazardous areas would automatically close and latch into the door frame. This deficient practice could affect staff and residents in each area. Findings include:	K 0321	WHAT CORRECTIVE ACTIO WILL BE ACCOMPLISHED F THOSE RESIDENTS FOUND HAVE BEEN AFFECTED BY DEFICIENT PRACTICE: No residents were affected.	OR TO

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155839	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	COMP	E SURVEY PLETED 2/2022
	PROVIDER OR SUPPLIE Γ HEALTH AND LIV		701 S I	ADDRESS, CITY, STATE, ZIP CO MAIN ST ITVILLE, IN 46070	'D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION OULD BE PROPRIATE	(X5) COMPLETION DATE
	with the Maintenan 12:05 p.m. to 1:30 supply, supply room storage room, are hare greater than 50 hazardous by code, self-closing device immediately latch at 10 to 30 second printerview at the tim Maintenance Superused as storage, we are considered hazarelectronic deadbolt frame.	ons during a tour of the facility are Supervisor on 12/22/22 from pm. the linen room 3, central m 1, laundry room, and oxygen azardous storage rooms that square feet or are considered, were all equipped with a on the door but did not into the frame when tested. In electronic deadbolt that has programmable delay. Based on the of observation, the revisor agreed the rooms were the larger than 50 square feet or ardous by code and stated the ardid not latch the door into the maintenance Supervisor at the		HOW OTHER RESIDENT HAVING THE POTENTI AFFECTED BY THE SAME DEFICIENT PRACTICE IDENTIFIED AND WHAT CORRECTIVE ACTION TAKEN: All residents could be affected and arrived on Jan 9, 23 doors without immediate devices were changed of Jan 11, 23 to doors that immediately upon locking of order is Attachment "INTERIOR OF THE WHAT MEASURES WILL PUT INTO PLACE AND SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE NOT RECUR: The Maintenance Direct check each door one ting to assure proper latching completed. See Attach WILL BE MONITORED ENSURE THE DEFICIE PRACTICE WILL NOT FOR WHAT QUALITY ASSUPROGRAM WILL BE PUPLACE: The results of these chediscussed during the quality and the puple of the set of t	IAL TO BE AME E WILL BE AT I WILL BE Iffected. I wen ordered B. All I we latching I changed on I latch Ing. Proof D." LL BE I WHAT WILL BE I WHAT WILL BE I AT THE I DOES I tor will Ine weekly I g is I ment "C" I WE ACTION TO ENT RECUR; RANCE UT INTO Ecks will be larterly	

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Í		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	f '			· ′	DATE SURVEY COMPLETED	
THE TENT		155839	B. WI		<u>. </u>	12/22/		
	PROVIDER OR SUPPLIES			701 S M	ADDRESS, CITY, STATE, ZIP COD MAIN ST TVILLE, IN 46070			
SUMMIN	HEALTH AND LIVI		_	SUMM				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
		CESC IDENTIFY THIS INFORMATION	1	IAG			DATE	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System Maintenance Fire Alarm System Maintenance A fire alarm system in accordance with complying with the National Electric (National Fire Alar Records of system and testing are re 9.6.1.3, 9.6.1.5, Nased on record registed to maintain 1 accordance with NI Sections 19.3.4.5.1 14.3.1 states that un 14.3.2, visual insperaccordance with the more often if requiring jurisdiction. Table must be visually insa. Control unit troub. Remote annunciate. Initiating devices fire alarm boxes, he etc.) d. Notification apple. Magnetic hold-op This deficient practifacility. Findings include: During records revisually insurance in the practical	n - Testing and n - Testing and m is tested and maintained h an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. n acceptance, maintenance adily available. IFPA 70, NFPA 72 view and interview, the facility of 1 fire alarm systems in FPA 72, as required by LSC 101 and 9.6. NFPA 72, Section alless otherwise permitted by rections shall be performed in e schedules in Table 14.3.1, or red by the authority having 14.3.1 states that the following spected semi-annually: ble signals ators s (e.g. duct detectors, manual cat detectors, smoke detectors, liances	K 0.		WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND HAVE BEEN AFFECTED BY DEFICIENT PRACTICE: No residents were affected HOW OTHER RESIDENTS HAVING THE POTENTIAL TO AFFECTED BY THE SAME DEFICIENT PRACTICE WILL IDENTIFIED AND WHAT CORRECTIVE ACTION WILL TAKEN: All residents could be affected that the company who does our inspections, Elwood Fire, has agreed to be responsible to perform a visual inspection of fire alarm system twice yearly assure compliance. The Maintenance Director has been re-educated regarding this mathematical transportant with the mathematical process.	OR OTO THE OBE BE BE d. the	01/08/2023	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155839	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE COMPI 12/22	LETED
	ROVIDER OR SUPPLIER		701 S I	ADDRESS, CITY, STATE, ZIP COD MAIN ST ITVILLE, IN 46070		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE
	records review, the stated a visual inspe six months prior to was not conducted.	on interview at the time of Maintenance Supervisor action of the fire alarm system the annual fire alarm inspection wiewed with the Administrator apervisor at the exit		WHAT MEASURES WILL PUT INTO PLACE AND W SYSTEMIC CHANGES W MADE TO ENSURE THA DEFICIENT PRACTICE I NOT RECUR: The Maint Director will be responsib assure that this is comple every six months. An aud used to assure compliance Attachment "C." HOW THE CORRECTIVE WILL BE MONITORED T ENSURE THE DEFICIEN PRACTICE WILL NOT RI WHAT QUALITY ASSUR PROGRAM WILL BE PUT PLACE: The Maintenance Directo bring the results of the mo to the quarterly QAPI mee assure compliance. This continue for a minimum o year.	WHAT VILL BE T THE DOES enance le to ted dit will be ee - E ACTION O IT ECUR; ANCE T INTO T will conitoring etings to s will	
K 0363 SS=E Bldg. 01	than required enclexits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are	corridor openings in other osures of vertical openings, is areas resist the passage made of 1 3/4 inch wood or other material in g fire for at least 20 fully sprinklered smoke only required to resist the expression of the corridor doors and doors are flammable or				

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	OF CORRECTION	IDENTIFICATION NUMBER 155839	A. BUILDING B. WING	01	COMPLETED 12/22/2022
	ROVIDER OR SUPPLIER		701 S N	ADDRESS, CITY, STATE, ZIP COD MAIN ST TVILLE, IN 46070	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	hardware. Roller la CMS regulation. T apply to auxiliary s flammable or comic Clearance betwee covering is not excording in the door closed what applied. There is closing of the door release when the compermitted. Nonrate unlimited height an meeting 19.3.6.3.6 frames shall be lated the interest in the exprinklered. Fixed allowed per 8.3. In there are no restrict resistance of glassiassemblies. 19.3.6.3, 42 CFR 1483, and 485 Show in REMARK fire protection ratin devices, etc.	n bottom of door and floor beeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping then a force of 5 lbf is no impediment to the standard to be a pushed or pulled are and protective plates of the permitted. Dutch doors are permitted. Dutch doors are permitted. Door beled and made of steel or compliance with 8.3, compartment is fire window assemblies are a sprinklered compartments of the permitted of the permitted. Parts 403, 418, 460, 482, Standard to doors such as ags, automatics closing			
	failed to ensure 6 of provided with a mea door closed, had no latching and would	an and interview, the facility 30 corridor doors were ans suitable for keeping the impediment to closing, resist the passage of smoke. ce could affect 15 residents.	K 0363	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND HAVE BEEN AFFECTED BY DEFICIENT PRACTICE: 1. No residents were affected	OR D TO THE
	Findings include:			The small wreath that was har on the residents door has bee removed. She put it there to	
	1.Based on observat	ion with the Maintenance		decorate for Christmas. She w	was

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155839	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 12/22/2022
		701 S	ADDRESS, CITY, STATE, ZIP COD MAIN ST IITVILLE, IN 46070		
PREFIX	(EACH DEFICIEN REGULATORY OI	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED OF THE A	LD BE COMPLETION DATE
	resident room door fully close and lated on the door knob. E of observation, the acknowledged the a would not close and removed first. The of observation. 2. Based on observ. Supervisor on 12/2.	to room 129 was unable to h because a wreath was hung Based on interview at the time Maintenance Supervisor aforementioned corridor door d latch unless the wreath was wreath was removed at the time ation with the Maintenance 2/22 at 12:30 pm, the corridor		informed that she cannot anything on her door knot 2. No residents were affect staff was in-serviced on 1 regarding the regulation to prop doors open. 3. The doorknob on the contract the therapy gym, therapy maintenance office and make been changed to hat that latch immediately.	b. ected. All 2/28/22 o not doors to kitchen, ned room
	with a chair. This is was removed at the deficient practice of staff. 3.Based on observation of supervisor on 12/2, the corridor doors to kitchen, maitenance failed to immediate use of an electronic second delay. These findings were	mpediment to closing the door time of observation. This ould affect 5 residents and		HOW OTHER RESIDENT HAVING THE POTENTIAL AFFECTED BY THE SAME DEFICIENT PRACTICE MIDENTIFIED AND WHAT CORRECTIVE ACTION MITAKEN: All residents could be affected to a mothing is left on a doorknown are propped open a doorknown on the specific latch immediately. Attach "C" The Maintenance Dir was re=educated on this See attachment "F."	AL TO BE ME MILL BE T MILL BE ected. r will do eassure nob, no eand the c rooms ment rector
				WHAT MEASURES WILL PUT INTO PLACE AND VICES OF SYSTEMIC CHANGES WILL MADE TO ENSURE THAT DEFICIENT PRACTICE IN NOT RECUR: The rounds audit will be of the Maintenance Direct weekly	WHAT VILL BE IT THE DOES completed

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	ILDING	onstruction 01	(X3) DATE COMPI	LETED
		155839	B. WI	NG		12/22	/2022
	PROVIDER OR SUPPLIE			701 S N	ADDRESS, CITY, STATE, ZIP COD MAIN ST TVILLE, IN 46070		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0522	NEDA 404				HOW THE CORRECTIVE AC WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECU WHAT QUALITY ASSURANC PROGRAM WILL BE PUT IN PLACE: The results of the rounds audi be discussed during the quart QAPI meetings to assure compliance. This will continue at least six months.	R; E ΓΟ t will erly	
K 0522 SS=D Bldg. 01	heating plant, is of combustible mater device, and has a and shut down ed excessive temper fuel fired, the device is chimney or vertakes air for combustible.	ting Device tee, other than a central designed and installed so erials cannot be ignited by a safety feature to stop fuel quipment if there is rature or ignition failure. If ice also: ent connected. Inbustion from outside. Install of the connected of the connec					
	Based on observati failed to ensure 1 c provided with intal outside for rooms of This deficient prac- rich with carbon m	on and interview, the facility of 1 mechanical rooms was see combustion air from the containing fuel fired equipment. tice could create an atmosphere onoxide which could cause for all staff and residents in the rea.	K 05	522	WHAT CORRECTIVE ACTIO WILL BE ACCOMPLISHED F THOSE RESIDENTS FOUND HAVE BEEN AFFECTED BY DEFICIENT PRACTICE: No residents were affected. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO AFFECTED BY THE SAME DEFICIENT PRACTICE WILL	OR TO THE	01/08/2023

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155839	l í	JILDING	onstruction 01	(X3) DATE COMPL 12/22/	ETED
	PROVIDER OR SUPPLIER			701 S N	ADDRESS, CITY, STATE, ZIP COD MAIN ST TVILLE, IN 46070		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	with the Maintenand 12:25 p.m., the med water heaters with a covered with lint and allow for fresh air to Based on an intervite the Maintenance Su covered with lint and	ons during a tour of the facility ce Supervisor on 12/22/22 at chanical room had fuel-fired a fresh air intake that was ad dirt. This condition does not to completely enter the room. It is at the time of observation, appervisor stated the intake was ad would need to be cleaned. In viewed with the Administrator appervisor at the exit			IDENTIFIED AND WHAT CORRECTIVE ACTION WILL TAKEN: All residents could be affected the intake in the Mechanical residents will be perfected that was dirty has been cleaned. WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: Cleaning of these vents and a other vents will be put on the preventative maintenance schedule to be completed by the Maintenance Director. See at Attachment "C" HOW THE CORRECTIVE ACT WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUL WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTENDED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUL WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTENDED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUL WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTENDED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUL WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTENDED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUL WHAT QUALITY ASSURANCE THE PROGRAM WILL BE PUT INTENDED TO THE PROGRAM WILL BE PUT INT	T BE IE S ny he udit	
K 0753 SS=F Bldg. 01	unless one of the o	orations orations shall be prohibited					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	r í	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER				COMPLETED	
155839		155839	B. WING 12/22/2022			/2022	
NAME OF PROVIDER OR SUPPLIER SUMMIT HEALTH AND LIVING			STREET ADDRESS, CITY, STATE, ZIP COD 701 S MAIN ST SUMMITVILLE, IN 46070				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	for product.						
	o Decorations r	neet NFPA 701.					
	o Decorations e	exhibit heat release less					
	than 100 kilowatts in accordance with NFPA 289.						
	o Decorations,	such as photographs,					
		er art are attached to the					
		I non-fire-rated doors in					
	_	8.7.5.6(4) or 19.7.5.6(4).					
		ons in existing occupancies					
	are in such limited quantities that a hazard of						
	fire development or spread is not present. 19.7.5.6						
	Based on observation and interview, the facility		K 0	753	WHAT CORRECTIVE ACTION		01/08/2023
	failed to ensure 17 of 19 corridor doors to resident				WILL BE ACCOMPLISHED F	OR	
	rooms were covered with wrapping paper that				THOSE RESIDENTS FOUND	THOSE RESIDENTS FOUND TO	
	covered 50-100 % o	of the door. LSC 19.7.5.6 states			HAVE BEEN AFFECTED BY	BEEN AFFECTED BY THE	
	combustible decorations shall be prohibited in				DEFICIENT PRACTICE:		
	any health care occupancy, unless one of the				All residents were affected. T	he	
	following criteria is				decorative coverings on the doors		
	(1) They are flame-retardant or are treated with				for Christmas) have been		
	approved fire-retardant coating that is listed and				removed.		
	labeled for application to the material to which it is						
	applied.						
	(2) The decorations meet the requirements of						
	NFPA 701, Standard Methods of Fire Tests for			HOW OTHER RESIDE			
	Flame Propagation of Textiles and Films.				HAVING THE POTENTIAL TO) BE	
	(3) The decorations exhibit a heat release rate not			AFFECTED BY THE SAME DEFICIENT PRACTICE WILL B			
	exceeding 100 kW when tested in accordance with					BE	
	NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW				IDENTIFIED AND WHAT		
		kages, using the 20 KW			CORRECTIVE ACTION WILL	RE	
	ignition source.	e such as photographs			TAKEN: All residents could be affected	ı	
	(4)*The decorations, such as photographs,				From this point on the doors w		
	paintings, and other art, are attached directly to				not have any decoration on th		
	the walls, ceiling, and non-fire-rated doors in accordance with the following:				that covers more than 30% of		
		non-fire-rated doors do not			entire door. The Maintenance		
		peration or any required			Director has been re-educated		
	_				Attachment "E"	4	
	latching of the door and do not exceed the area limitations of 18.7.5.6(b), (c), or (d).				, addinione L		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155839		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/22/2022				
NAME OF PROVIDER OR SUPPLIER SUMMIT HEALTH AND LIVING				STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPRIA' DEFICIENCY)	ſĒ	(X5) COMPLETION DATE		
	wall, ceiling, and do space of a smoke corprotected throughout sprinkler system in (c) Decorations do a wall, ceiling, and do space of a smoke conthroughout by an apsprinkler system in (d) Decorations do a wall, ceiling, and do sleeping rooms have four persons, in a small protected throughout automatic sprinkler Section 9.7. This deficient practical and staff. Findings include: Based on observation with the Maintenance 12:05 pm to 1:30 pm corridor doors were decoration that cover doors. Based on into observation, the Mathe corridor doors were combustible decoration. These findings were	tion. e reviewed with the Maintnenance Supervisor at			WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The Maintenance Director will walk throughs 5 X's weekly to assure that there is nothing puthe doors that would be hazard materials. HOW THE CORRECTIVE ACT WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUI WHAT QUALITY ASSURANC PROGRAM WILL BE PUT INTENT PLACE: The results of this monitoring with the discussed during the quarter QAPI meetings. This will contifor at least six months.	BE E S do t on dous FION S; E O will erly			
K 0754 SS=E	NFPA 101 Soiled Linen and ⁻	Trash Containers							

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV		SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLE		ETED		
155839		155839	B. WING 12/22/2		2022		
				CTD FFT A	DDDFGG CITY CTATE TIP COD		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
CHAMAIT LIE ALTH AND LIVING				701 S M			
SUMMIT HEALTH AND LIVING			SUMMITVILLE, IN 46070				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	_	DATE
Bldg. 01	Soiled Linen and 1	Frash Containers					
	Soiled linen or tras	sh collection receptacles					
	shall not exceed 3	2 gallons in capacity. The					
		f container capacity in a					
	room or space sha						
		et. A total container					
	-	ons shall not be exceeded					
		are feet area. Mobile soiled					
	•	ection receptacles with					
		than 32 gallons shall be					
		protected as a hazardous					
	area when not atte						
	Containers used solely for recycling are						
	permitted to be ex	cluded from the above					
	-	re each container is less					
	than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard						
	6921 or equivalent.						
	18.7.5.7, 19.7.5.7						
	Based on observation and interview, the facility		K_0	754	WHAT CORRECTIVE ACTION	١	01/08/2023
	failed to ensure trasl	h receptacles in 1 of 4	12 0 / 0 .		WILL BE ACCOMPLISHED FO	OR .	
	corridors were main	tained in accordance with			THOSE RESIDENTS FOUND TO		
	19.7.5.7. This deficient practice could affect staff and up to 20 residents in the front hall. Findings include:				HAVE BEEN AFFECTED BY THE		
					DEFICIENT PRACTICE:		
					No residents were affected.		
	Based on observations during a tour of the facility						
	with the Maintenance Supervisor on 12/22/25 at 1:05 p.m., there were two 20-gallon trash barrels				HOW OTHER RESIDENTS		
					HAVING THE POTENTIAL TO) BE	
	within a 64 square f	eet area in the front hallway in			AFFECTED BY THE SAME		
	the vicinity of room	120. Based on interview at the			DEFICIENT PRACTICE WILL	BE	
	time of observation,	the Maintenance Director			IDENTIFIED AND WHAT		
	stated there were tw	o 20-gallon barrels of trash			CORRECTIVE ACTION WILL	BE	
	totaling 40 gallons on the front hallway.				TAKEN:		
					All residents could be affected		
	The finding was rev	iewed with the Administrator			All trash cans outside of rooms	3	
	and the Maintenance Supervisor during the exit conference.				have been removed and replac	ced	
					by small cans located inside		

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 155839		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 12/22/2022		
NAME OF PROVIDER OR SUPPLIER SUMMIT HEALTH AND LIVING		STREET ADDRESS, CITY, STATE, ZIP COD 701 S MAIN ST SUMMITVILLE, IN 46070					
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
	3.1-19(b)			resident's rooms. WHAT MEASURES WILL BE PUT INTO PLACE AND WHA SYSTEMIC CHANGES WILL MADE TO ENSURE THAT TH	T BE IE		
				DEFICIENT PRACTICE DOES NOT RECUR: During the daily walk throughs the Maintenance Director, the placement of trash cans will be monitored to assure that none outside of the rooms. See Attachment "C."	s by e		
				HOW THE CORRECTIVE AC WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECU WHAT QUALITY ASSURANC PROGRAM WILL BE PUT IN PLACE: The results of this monitoring be discussed during the quart QAPI meeting. This will be ongoing for at least six months.	R; E ΓΟ will erly		

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